Authority

Federal: Title XIX of the Social Security Act, Public Law 89-97, as amended
State: Title 32.1, Chapter 10, *Code of Virginia*

Establishment of the National Medicaid Program

Medicaid is a jointly funded cooperative venture between the federal and state governments for the purpose of providing medical care for certain groups of low-income individuals who are aged, blind or disabled; members of families with children; and pregnant women. Within frequently changing federal guidelines, each state designs and administers its own program, a practice that creates substantial variation among state programs in terms of persons covered, types and scope of benefits offered, and the amount of payments for services. The program was authorized as part of the *Social Security Act Amendments of 1965* and signed into law on July 30, 1965, by President Lyndon B. Johnson.

Medicaid grew out of and replaced two earlier programs of federal grants to states to provide medical care to low-income persons. The first was a vendor payment program for welfare recipients, enacted in 1950, and the second was the Kerr-Mills medical assistance program for the aged, enacted in 1960. Before 1950, welfare payments might include a small amount nominally earmarked for medical expenses, but the payments were made to the recipient and could be used for any purpose the recipient chose. The *Social Security Amendments of 1950* provided federal matching funds for direct state payments to medical care providers (or "vendors") on behalf of recipients of public assistance.

By 1965, improving medical coverage for the elderly had become a major congressional priority. Congress considered a number of approaches, including a universal system based on Social Security, a voluntary program supported in part by beneficiary premiums, and an expansion of the means-tested Kerr-Mills program for the low-income elderly only. What was adopted in the *Social Security Amendments of 1965* represented a combination of all three approaches.

Medicare hospital insurance (Part A) was a social insurance program covering nearly all of the elderly, while Medicare's supplementary medical insurance program (Part B) was a voluntary program. Both programs, however, could leave some elderly beneficiaries exposed to substantial costs for premiums, deductibles, and coinsurance payments, as well as costs for uncovered services. A third component, an expansion of Kerr-Mills to be called Medicaid was included in order to help the low-income elderly meet these costs. At the same time, the new program would consolidate and simplify the other existing federal efforts to provide medical assistance to the poor, the vendor payment programs for cash assistance recipients. In addition, it would extend the Kerr-Mills concept of medical need to other populations, including families with children, the blind, and the disabled.

The new Medicaid program carried over two key features of its predecessors: (1) states were given substantial latitude to design their own programs, so long as they met minimum federal standards and (2) coverage was largely confined to the populations traditionally eligible for welfare--certain families with children (chiefly single-parent families) and the aged, blind and disabled. States were free to provide medically needy coverage for higher income persons in the traditional welfare categories.

Despite this flexibility, Medicaid was not expected to result in a dramatic expansion of coverage. Maximum new federal expenditures, even if all states took full advantage of the new program, were projected to be $238 million per year above those under the vendor payment/Kerr-Mills programs, which totaled $1.3 billion in 1965. In fact, the $238 million estimate was exceeded in the first year of the program, although only six states had implemented programs. By 1998, Medicaid provided health and long-term care coverage to approximately 31million low-income individuals--more than 1 in 10 Americans--at an estimated cost of $169 billion. As expenditures have grown, Medicaid has become a major budgetary commitment for both the federal and state governments. The expenditure explosion is generally attributed to three factors:

- Federally required legislative expansions, especially for pregnant women and children, have significantly increased the number of persons receiving Medicaid benefits. In addition, the use of Medicaid as a safety net for the elderly and disabled populations has had a substantial impact on costs.

- The growth in the cost of medical care has outstripped the overall rate of inflation in recent years. The cost of medical care in the general economy impinges upon the cost of medical care provided by the Medicaid program. Federal standards regarding the "reasonableness" of payments to nursing homes and hospitals have contributed to the growth in costs.

- Payments to state facilities have increased as states took advantage of federal rules that permit coverage of certain services that would be paid solely with state funds if federal participation were not available through Medicaid.

Being poor does not automatically qualify an individual for Medicaid. Only persons who fall into particular "categories" such as people receiving cash assistance or low-income children and pregnant women are eligible. Although Medicaid has increasingly been used to expand coverage to the low-income population, it covers only 55 percent of poor Americans. Millions of uninsured low-income Americans are beyond the program's reach.

Program Financing

Medicaid is an entitlement program. Entitlement programs provide benefits to all people or jurisdictions who are eligible to receive benefits. Rather than being determined by the annual appropriation process, spending levels for entitlements are determined by the number of persons who participate in the program and program benefit levels. Medicaid funds, however, still come from federal general funds as there is no trust fund like that established for some other entitlement programs such as Social Security and Part A of Medicare.

Medicaid services and associated administrative costs are jointly financed by the federal government and the states. The Federal Medical Assistance Percentage (FMAP) is calculated annually for each state and determines the amount by which the federal government will participate in the funding of that state's Medicaid program. The FMAP process is designed to provide a higher federal matching rate to states with lower per capita incomes. No state may have a FMAP lower than 50 percent or higher than 83 percent. The federal share of administrative costs is 50 percent for all states, although higher rates are applicable for specific items.

Participating states are responsible for the nonfederal share of Medicaid payments. Like the federal government, states usually rely on general funds for Medicaid spending.

Federal Mandates

Over the years the U.S. Congress has enacted a steady stream of mandates that has greatly expanded the Medicaid Program beyond the scope envisioned by its founders. The most far-reaching of these began with the *Deficit Reduction Act of 1984*, when Congress moved to expand Medicaid eligibility to increasing numbers of pregnant women and children in order to reduce infant mortality and improve access to child health services. These changes allowed higher-income persons to qualify for Medicaid and also partially severed the link between Medicaid and the cash assistance programs by extending coverage to families that did not fit into traditional welfare categories. Other mandates focused on expanding Medicaid coverage to low-income Medicare beneficiaries, the establishment of special eligibility rules for institutionalized persons whose spouse remained in the community, the improvement of certain aspects of service coverage and the raising of reimbursement levels.

A summary of the major federal Medicaid legislation is shown on the following pages.

Major Medicaid Legislation, 1965 to Present

1965

- **Social Security Amendments of 1965 (P.L. 89-97)**
  Established the Medicaid program.

1967

- **Social Security Amendments of 1967 (P.L. 90-248)**
  Limited financial standards for the medically needy.
  Established the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program to improve child health.
  Permitted Medicaid beneficiaries to use providers of their choice.

1971

- **Act of December 14, 1971 (P.L. 92-223)**
  Allowed states to cover services in intermediate care facilities (ICFs) and ICFs for the mentally retarded (ICF/MR).

1972

- **Social Security Amendments of 1972 (P.L. 92-603)**
  Repealed 1965 provision requiring states to move toward comprehensive Medicaid coverage.
  Allowed states to cover care for beneficiaries under age 22 in psychiatric hospitals.

1977

- **Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (P.L. 95-142)**
  Established Medicaid Fraud Control Units.

1980

- **Mental Health Systems Act (P.L. 96-398)**
  Required most states to develop a computerized Medicaid Management Information System (MMIS).

- **Omnibus Reconciliation Act of 1980 (P.L. 96-499)**
  Boren amendment permitted states to establish payment systems for nursing home care in lieu of Medicare's rules.

1981

- **Omnibus Budget Reconciliation Act of 1981 (OBRA '88, P.L. 97-35)**
  Enacted three-year reductions in federal matching percentages for states whose spending exceeded growth targets.
  Established section 1915(b) and 1915(c) waivers (freedom-of-choice and home and community-based services).
  Extended the Boren amendment to inpatient hospital services.
  Eliminated special penalties for noncompliance with EPSDT requirements and gave states with medically needy programs broader authority to limit coverage.

- **Deficit Reduction Act of 1984 (DEFRA, P.L. 98-369)**
  Eliminated categorical tests for certain pregnant women and young children.

Major Medicaid Legislation, 1965 to Present--Continued

1986

- **Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272)**
  - Extended coverage to all pregnant women meeting AFDC financial standards.

- **Omnibus Budget Reconciliation Act of 1986 (OBRA '86, P.L. 99-509)**
  - Allowed coverage of pregnant women and young children with incomes up to 100 percent of poverty level; women receive pregnancy-related services only.
  - Allowed Medicare buy-in for Qualified Medicare Beneficiaries (QMBs) with incomes up to 100 percent of poverty level under certain resource constraints.
  - Required continuation of eligibility for infants and children if they are hospital inpatients when the age limit of eligibility is reached.
  - Established a new mandatory categorically needy coverage group for severely impaired individuals under 65.
  - Allowed coverage of at-home respiratory care services.
  - Required provision of emergency services to aliens if otherwise eligible (financially and categorically).

- **Employment Opportunities for Disabled Americans Act of 1986 (P.L. 99-643)**
  - Made permanent a previous demonstration program for disabled individuals who are able to engage in substantial gainful activity.

- **Immigration Reform and Control Act of 1986 (P.L. 99-643)**
  - Required provision of emergency services (including delivery) to newly legalized aliens if otherwise eligible and full coverage for eligibles under 18 years of age.

1987

- **Medicare and Medicaid Patient and Program Protection Act of 1987 (P.L. 100-93)**
  - Strengthened authorities to sanction and exclude providers.

- **Omnibus Budget Reconciliation Act of 1987 (OBRA '87, P.L. 100-203)**
  - Allowed coverage of pregnant women and infants with incomes up to 185 percent of poverty level.
  - Required pre-admission screening programs and annual resident reviews for mentally ill and retarded.
  - Strengthened OBRA '81 requirement that states provide additional payment to hospitals treating a disproportionate share of low-income patients.

Major Medicaid Legislation, 1965 to Present--Continued

1988

- **Medicare Catastrophic Coverage Act of 1988 (MCCA, P.L. 100-360)**
  - Mandated coverage of pregnant women and infants with incomes up to 100 percent of poverty level.
  - Mandated the OBRA '86 expanded coverage of low-income Medicare beneficiaries.
  - Established special eligibility rules for institutionalized persons whose spouse remained in the community to prevent "spousal impoverishment".
- **Family Support Act of 1988 (P.L. 100-485)**
  - Extended work transition coverage for families losing AFDC because of increased earnings and expanded coverage for two-parent families whose principal earner was unemployed (AFDC-U).

1989

- **Omnibus Budget Reconciliation Act of 1989 (OBRA '89, P.L. 101-239)**
  - Mandated coverage of pregnant women and children under age six with incomes up to 133 percent of poverty level.
  - Expanded EPSDT program requirements by mandating treatment to correct problems identified during an EPSDT screening even if the treatment is not covered otherwise under the state's Medicaid Plan.
  - Mandated coverage and full-cost reimbursement of federally qualified health centers (FQHCs).

1990

- **Omnibus Budget Reconciliation Act of 1990 (OBRA '90, P.L. 101-508)**
  - Mandated phased in coverage of children ages six through 18 with incomes up to 100 percent of poverty level.
  - Mandated the OBRA '86 option of continuous eligibility through the postpartum period.
  - Extended period of presumptive eligibility before written applicants must be submitted (Presumptive eligibility itself is optional).
  - Mandated coverage of low-income Medicare beneficiaries:
    - SLMBs with incomes up to 110 percent of poverty covered effective January 1, 1993; with incomes up to 120 percent of poverty covered effective January 1, 1995.
  - Established Medicaid prescription drug rebate program.
  - Mandated states to receive and process applications at convenient outreach sites.
  - Permitted states to provide home and community-based services to functionally disabled elderly and to provide community-supported living arrangements to mentally retarded and developmentally disabled.

1991

- **Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234)**
  - Restricted use of provider donations and taxes as State share of Medicaid spending; limited disproportionate share hospital payments.

Major Medicaid Legislation, 1965 to Present--Continued

1996

Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform, P.L. 104-193))

Temporary Assistance for Needy Families (TANF):

Aid to Families with Dependent Children (AFDC) is replaced by Temporary Assistance for Needy Families (TANF), a block grant to the states. States are given the flexibility to determine TANF eligibility criteria and the form and extent of benefits with some restrictions.

States must continue Medicaid for:

- Families losing TANF cash benefits because of income received from collection of spousal or child support under federal support laws.
- Minor mothers denied TANF cash because they do not live with a parent or certain other adult relatives.
- Families losing eligibility due to increased hours of or earnings from employment.

States may elect to terminate Medicaid for individuals denied receipt of TANF cash assistance who fail to comply with TANF work requirements. However, states may not terminate Medicaid for poverty-related groups and minor children who are not the heads of households.

States with waivers of AFDC that affect Medicaid can choose to continue them after enactment indefinitely.

State-established medically needy income levels continue to be capped at 133 1/3 percent of AFDC, except AFDC levels are based on those in effect on July 16, 1996, which may increase at state option, by as much as the percentage increase in the CPI-U.

States are allowed to use one application form for assistance under Title IV-A and Medicaid assistance under Title XIX.

Aliens:

The Medicaid eligibility of all aliens is subject to specific limitations which is largely dependent on the alien's status as defined in the Act, date of entry into the United States, length of stay and quarters of work. Only qualified aliens are eligible for full Medicaid benefits. Certain other groups are no longer eligible for full Medicaid benefits, but are eligible for treatment of an emergency medical condition. However, honorably discharged veterans and active duty military, their spouses and children who are aliens lawfully residing in the state are eligible for full Medicaid benefits regardless of length of stay or date of entry as long as all Medicaid eligibility requirements are met.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.L. 104-191)

Health Insurance Reform:

Title I of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects health insurance coverage for workers and their families when they change or lose their jobs.

Major Medicaid Legislation, 1965 to Present--Continued

Health Insurance Portability and Accountability Act of 1996 (HIPAA) ***continued***

Standards for Privacy of Individually Identifiable Health Information:

HHS published the final Privacy Rule on December 28, 2000. The final rule took effect on April 14, 2001. This rule gives patients greater access to their own medical records and more control over how their personal health information is used. The rule also addresses the obligations of health care providers and health plans to protect health information. By law, covered entities include health plans, health care clearinghouses, and health care providers who conduct certain financial and administrative transactions electronically have until April 14, 2003, to comply. Small health plans have until April 14, 2004, to comply.

Transactions and Code Sets:

This rule adopts standards for eight electronic transactions and for code sets to be used in those transactions. It also contains requirements concerning the use of these standards by health plans, health care clearinghouses, and certain health care providers. The effective date of this rule is October 16, 2000. The compliance date for transactions and code set is October 16,2002.

The use of these standard transactions and code sets will improve the Medicare and Medicaid programs and other Federal health programs and private health programs, and the effectiveness and efficiency of the health care industry in general, by simplifying the administration of the system and enabling the efficient electronic transmission of certain health information. It implements some of the requirements of the Administrative Simplification subtitle of the Health Insurance Portability and Accountability Act of 1996.

1997

Balanced Budget Act of 1997 (P.L. 105-33)

Financing:

Repealed the Boren amendment requirement related to adequate payment for nursing home and hospital services and replaced it with a requirement to publish proposed rates and methodology for public review and comment.

Allowed states the option of paying Medicare providers no more than the difference between the Medicare payment and the state's Medicaid rate for that service.

Eliminates over time the requirement that states pay 100% of reasonable costs for FQHCs and RHCs.

Establishes limits on federal matching funds for payments to hospitals entitled to disproportionate share adjustments.

Eligibility:

Offers states the option to guarantee eligibility for a child under 19 years for up to 12 months.

Offers states the option to use presumptive eligibility.

Requires states to pay for Medicare Part B premiums for individuals whose income is between 120% and 135% of the federal poverty level and to pay for the difference between the old law and the new law Medicare Part B premiums for individuals whose income is between 135% and 175% of the federal poverty level.

Balanced Budget Act of 1997 (P.L. 105-33) *continued*

Managed Care:

Gives states the option of requiring managed care or primary care case management enrollment as part of the state plan. Removes requirement to seek a waiver in specified circumstances.

Gives state Medicaid agencies authority to lock in enrollment in an HMO for 12 months.

Expands requirements related to the quality of services provided by a managed care entity.

Requires managed care plans to cover emergency services without regard to prior authorization and also includes the "prudent layperson's" definition of emergency services.

PACE (Program for All-inclusive Care for the Elderly):

Establishes PACE as a state plan option. PACE programs typically capitate all acute and long-term care services.

State Children's Health Insurance Program:

Creates a new Title XXI, the state Children's Health Insurance Program. This program gives states an enhanced match to provide health insurance to children not eligible for Medicaid and with income under 200 percent of the federal poverty level. States can design their own program within guidelines or expand Medicaid.

Establishment of the Virginia Medicaid Program

In December 1965, the Governor's Advisory Committee on Medicare and Medicaid recommended that the Virginia Department of Health be designated as the single state agency responsible for administering the Virginia Medicaid Program. The 1966 General Assembly authorized the State Health Commissioner to prepare and submit a plan for medical assistance to the U.S. Department of Health, Education and Welfare (HEW), subject to approval of the State Board of Health. The *Virginia State Plan for Medical Assistance* was approved by HEW in June 1969, and on July 1, 1969, the program was implemented on a state-wide basis.

Department of Medical Assistance Services (DMAS)

Administration of the program was separated from the Virginia Department of Health on March 1, 1985, when the Department of Medical Assistance Services (DMAS) was created and designated as the single state agency charged with administering the *Virginia State Plan for Medical Assistance*. The agency has also been assigned responsibility for administering additional indigent health care financing programs which are shown on the following page. DMAS is responsible for integrating and coordinating these programs with other state and federal programs that provide health care financial assistance. It also ensures that health care services are available to financially needy and medically indigent individuals and makes prompt, appropriate and equitable payments for medical services after ensuring that all other payment resources are exhausted. In addition, the agency ensures that services are medically necessary and of acceptable quality and that services and payments are in compliance with state, federal and program regulations.

The agency's current mission statement and values was adopted in 2002 and reads as follows:

Mission:

To provide a system of high quality comprehensive health services to qualifying Virginians and their families.

DMAS operates under the direction of the Director of Medical Assistance Services, who is appointed by the Governor and reports to the Secretary of Health and Human Resources. Responsibility for maintaining the *Virginia State Plan for Medical Assistance* rests with the Board of Medical Assistance Services, which directs the preparation and submission of amendments to the Secretary of the United States Department of Health and Human Services, subject to approval of the Governor. The Board consists of eleven residents of the Commonwealth appointed by the Governor, five who are health care providers and six who are not. Members are appointed for four-year terms and no member is eligible to serve on the Board for more than two full consecutive terms. The Director is the executive officer of the Board but is not a member.

Health Care Programs Administered by The Virginia Department of Medical Assistance Services

1985 u **Virginia Medicaid Program**

- DMAS was created and designated as the single state agency charged with administering the *Virginia State Plan for Medical Assistance.*

1989 u **State/Local Hospitalization Program (SLH)**

- The General Assembly eliminated the voluntary program that had been established in 1944 and enacted a mandatory statewide program. The new program requires all localities within the Commonwealth to participate and mandates a local match, not to exceed 25% of the program benefit expenditures. Administration of the Program was transferred from the localities and the Department of Social Services to DMAS.

1989 u **Indigent Health Care Trust Fund**

- The General Assembly created the Trust Fund effective 7-1-89 as a public/private partnership involving the state government and private acute care hospitals in the state. The Fund's purpose is to reimburse hospitals for the cost of that part of charity care for which no payment is received and which is provided to any person whose annual family income is equal to or less than 100 percent of the federal poverty level. Administration of the Program was assigned to DMAS.

1995 u **Health Premium Assistance Program for HIV-Positive Individuals**

- The General Assembly enacted a program to provide a health premium assistance program for HIV-positive individuals as set forth in section 32.1-330.1 of the *Code of Virginia*. The program was initially funded with federal Ryan White Act funds, but beginning in 1998 has been funded completely with General Funds. Administration of the Program was assigned to DMAS.

1996 u **Involuntary Mental Commitments**

- Provision of medical services under the program was transferred from the Supreme Court to DMAS. The program provides for reimbursement of services provided to non-Medicaid recipient's incident to involuntary mental commitment detentions and hearings.

1997 u **Regular Assisted Living Payments for Residents of Adult Homes**

- The General Assembly enacted a program to provide services in a licensed adult care residence (ACR) for auxiliary grant or general relief adults who may have physical or mental impairments and require at least moderate assistance with two or more activities of daily living (ADLs). (This is no longer a Medicaid program. State funds pay for services exclusively provided to persons with dependencies in four or more ADLs.) Administration of the Program was assigned to DMAS.

1998 u **Virginia Children's Medical Security Insurance Plan (CMSIP)**

- The CMSIP Program was enacted to provide comprehensive health benefits to children through the age of 18 in families with incomes under 185 percent of the federal poverty level who do not have any health insurance coverage but are not eligible for Medicaid. The state and federal governments share in the costs of the program. Administration of the program was assigned to DMAS.

Health Care Programs Administered by The Virginia Department of Medical Assistance Services (continued)

2000

Family Access to Medical Insurance Security Plan (FAMIS)

- The FAMIS Program was enacted to replace the CMSIP program. It is designed to provide comprehensive health benefits to children through the age of 18, in families with incomes at or below 200 percent of the federal poverty level who do not have any health insurance coverage but are not eligible for Medicaid. FAMIS has enhanced benefits and contains an employer-employee health insurance premium payment component. The state and federal governments share in the costs of the program. Administration of the program was assigned to DMAS. FAMIS was approved by the federal health care agency known as the led the Centers for Medicare and Medicaid Services (CMS), formerly called the Health Care Financing and Administration (HCFA), in December 2000.

2001

- The FAMIS program was implemented and became operational along with the Central Processing Unit (CPU) on August 1, 2001. Most enrollees moved into managed care effective December 1, 2001. The twelve-month waiting period for prior insurance was shortened to six months. Premiums for families with income greater than 150% FPL was discontinued.

2002

Children's Health Insurance Program - FAMIS and Medicaid

- Medicaid coverage of children age 6-19 with family income between 100 – 133% FPL began September 1, 2002. This expansion is funded by Title XXI though some children who do not qualify for Title XXI funding for reasons other than income are now enrolled in Medicaid under this eligibility level. FAMIS eligible children were moved to Medicaid if income was within stated limits. Effective September 1, 2002, a joint FAMIS/Medicaid application was developed and local social services offices could again accept and determine eligibility for both programs. FAMIS case maintenance remained with the Central Processing Unit. Additional changes were made to bring FAMIS and Medicaid policies into alignment.

2003

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Children's Health Insurance Program - FAMIS and Medicaid

- 2003 General Assembly mandated changes were implemented on August 1, 2003. 1) the new program name for children enrolled in medically indigent Medicaid, “FAMIS Plus,” was introduced as part of the Children’s Health Insurance umbrella program that consists of FAMIS and children’s Medicaid, 2) FAMIS eligibility is continued for 12 months and will be canceled before the annual renewal only if a child turns age 19, a child moves out of Virginia, the family’s income increases to an amount that is over 200% FPL, or the DMAS insurance card is returned by the Post Office and the family cannot be located; 3) the FAMIS 6-month “waiting period” for children whose private health insurance was canceled was changed to 4 months; and 4) four community mental health services were added to the FAMIS benefit package - Intensive In Home for Children/Adolescents, Crisis Intervention-Mental Health, Case Management, Targeted Mental Health, and Day Treatment for Children.

General Description of Eligibility

Individuals originally became eligible for Medicaid because of their "categorical" relationship to two federal cash assistance programs: Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI). However, congressional mandates in the late 1980s and 1990s resulted in dramatic changes in Medicaid eligibility provisions. Now, individuals in additional selected low-income groups are eligible for Medicaid solely on the relationship of their incomes to the Federal Poverty Guidelines. New Federal Poverty Guidelines are published annually in the *Federal Register* and become effective upon publication.

Medicaid is a means-tested program. Applicants' income and other resources must be within program financial standards, which vary from state-to-state, and different standards apply to different population groups within a state. The Program does not cover everyone who is poor, but rather is available only to members of families with children (often times only the children are covered) and pregnant women, and to persons who are aged, blind or disabled. Persons not falling into those categories—such as single adults and childless couples under the age of 65—cannot qualify for Medicaid, no matter how low their income.

The Medicaid statute defines over 50 distinct population groups as potentially eligible, including those for which coverage is mandated by the federal government and those that may be covered at state option. Despite the complexity of Medicaid eligibility, most of the coverage categories fall into six basic groups:

1. ***Low income families with children*** who meet the eligibility requirements of the State's July 16, 1996 AFDC Plan.

2. ***Aged, Blind, or Disabled*** individuals with income below a state specified percentage of poverty. Supplemental Security Income (SSI) recipients receive Medicaid automatically, in all but a few states. (See 209(b) option below.)

3. ***Low-income pregnant women and children*** who do not qualify for AFDC, either because their income is too high or because they fail to meet the program's categorical restrictions. Expansion of mandatory and optional coverage for non-AFDC pregnant women and children was a major theme of federal Medicaid legislation in the 1980s.

4. ***The medically needy***, persons who do not meet the financial standards for cash assistance programs but meet the categorical standards and have income and resources within special medically needy limits established by the states. Persons whose incomes or resources are above the standards may qualify by "spending down", incurring medical bills that reduce their income and/or resources to the necessary levels. Coverage of the medically needy is optional; 41 states and other jurisdictions cover at least some groups of the medically needy.

5. ***Persons requiring institutional care.*** Special eligibility rules apply to persons receiving care in nursing facilities (SNFs) or intermediate care facilities for the mentally retarded (ICF/MRs) or who are participating in alternative community care programs for the aged and disabled. Many of these persons may have incomes well above the poverty level but qualify for Medicaid because of the very high cost of their care.

6 ***Low-income Medicare beneficiaries.*** Medicaid pays required Medicare premiums, deductibles, and coinsurance on behalf of low-income aged and disabled Medicare beneficiaries. (Coverage is restricted to Medicare cost-sharing unless the beneficiary also qualifies for Medicaid in some other way.)

Eligibility under Virginia Medicaid

The Virginia Medicaid Program initially covered only the "categorically needy" who were required to be covered by Federal law because of their relationship to categories of public assistance under the *Social Security Act*. On January 1, 1970, six months after being implemented on a statewide basis, the program was expanded to include certain benefits for individuals who are "Medically Needy". Persons in this group are able to provide their food, clothing and shelter, but in the view of the state, do not have sufficient funds to pay for their medical care. To be eligible, the Medically Needy individual must also be blind, totally disabled, or 65 or older, or a dependent child (categorically related). Their income may exceed basic public assistance standards, but must be less than the medical assistance income levels established for the Medicaid Program.

The current eligibility categories and their relationship to public cash assistance programs are shown on the following pages.

MEDICAID ELIGIBILITY CATEGORIES IN VIRGINIA
AND THEIR RELATIONSHIP TO
PUBLIC CASH ASSISTANCE PROGRAMS

Cash Assistance Program	Medicaid Category
Supplemental Security Income: A program for the aged, blind and disabled who need cash assistance to pay for food, clothing and shelter.	**Aged:** Individuals who are aged 65 and older. **Blind:** Individuals who are statutorily blind. **Disabled:** Individuals who are unable to perform any substantial gainful activity by reasons of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. **Qualified Medicare Beneficiary (QMB):** An aged, blind or disabled individual who is eligible for Medicare Part A and who meets the QMB income and resource limits. **Qualified Disabled and Working Individual:** An individual who is entitled to enroll for Part A Medicare, who is not otherwise eligible for Medicaid and who meets the QDWI income and resource limits. These individuals are eligible for Medicaid payment of Medicare Part A premiums only. **Qualified Severely Disabled Individual (QSDI):** A disabled individual who received Supplemental Security Income and Medicaid but who lost SSI because of increased earnings from employment, and the Social Security Administration determined that the individual: • Continues to have a disabling impairment; • Would, except for earnings, continue to be eligible for SSI; • Would be seriously inhibited from continuing or obtaining employment without Medicaid benefits; and • Whose earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the benefits under SSI, Medicaid and publicly funded attendant care services that would be available to him in the absence of such earnings.

Cash Assistance Program	Medicaid Category
	Special Low Income Medicare Beneficiary (SLMB): Individuals who would be Qualified Medicare Beneficiaries but for the fact that their income exceeds 100% but is less than 120% of Federal Poverty Guidelines (effective January 1, 1995). These individuals are eligible for Medicaid payment of Medicare Part B premiums only. **Qualified Individuals – Group 1 (QI-1):** Individuals who would be Qualified Medicare Beneficiaries but for the fact that their income exceeds 100% but is less than 135% of Federal Poverty Guidelines (effective January 1, 1998). These individuals are eligible for Medicaid payment of Medicare Part B premiums only. Coverage for this group is not an entitlement. Individuals must apply each year and are enrolled as long as funds are available. **Qualified Individuals – Group 2 (QI-2):** Individuals who would be Qualified Medicare Beneficiaries but for the fact that their income exceeds 100% but is less than 175% of Federal Poverty Guidelines (effective January 1, 1998). These individuals were eligible for Medicaid payment of the portion of the Medicare Part B premium attributable to the cost of transferring coverage of home health services to Medicare Part B from Medicare Part A. Federal authority for this group expired and Medicaid coverage for this component ended December 31, 2002.
Temporary Assistance for Needy Families (TANF): The Personal Responsibility and Work Opportunities Act of 1996 (P.L.104-193) eliminated the Aid to Families with Dependent Children (AFDC) cash assistance program. AFDC was for families in which one or more parents was absent, disabled or unemployed, and the family needed cash assistance for food, shelter, clothing and child care. Families who met the AFDC eligibility criteria that were in effect prior to TANF enactment, can be eligible since Medicaid used the criteria of the old AFDC program in determining eligibility.	**Low Income Families with Children:** Families with children who meet the eligibility requirements of the state's July 16, 1996 AFDC Plan. **Foster Care/Corrections Child:** A child under age 21 in the custody of a public or private child-caring agency or a child in the custody of the Department of Youth and Family Services or a local court services unit *who is not in secure detention*. **Subsidized Adoptions Child:** A child under age 21 for whom there is an adoption subsidy agreement in effect. There are two types of adoption subsidy agreements: one meeting the requirements of Title IV-E of the *Social Security Act* (mandated group) and one which is funded by state and local funds (optional group). **Child Under Age 21 in a Nursing Facility:** An individual who resides in a nursing facility.

	Medicaid Category
Federal Poverty Level Groups: Individuals eligible for Medicaid because of the relationship of their income to the federal poverty guideline.	**Pregnant Woman:** A woman whose pregnancy is medically certified. Individuals in this category continue eligibility until 60 days after the pregnancy is terminated. **Indigent Child Under Age 6:** Any child who meets both the age and financial eligibility criteria. Virginia covers such children with incomes up to 133 percent of the federal poverty level after the application of various income disregards. *The child does not have to be deprived of parental support or care.* **Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA):** Any woman with income up to 200% of the federal poverty level who has been screened and certified as needing treatment for breast or cervical cancer (including pre-cancerous conditions) by a medical provider operating under the Center for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program (effective July 1, 2001). **Family Planning Services:** Any woman who received pregnancy-related services on or after October 1, 2002, paid for by Medicaid, who has countable income less than or equal to 133% of the federal poverty level (effective October 1, 2002). Women in this group only receive Medicaid coverage for family planning services. **Indigent Child Between Ages 6 and 19:** A child who was born after September 30, 1973, and has attained 6 years of age but who has not attained 19 years of age. *These children need not be deprived of parental support or care.* Virginia currently covers such children with incomes up to 100 percent of the federal poverty level after the application of various income disregards.
Auxiliary Grant (AG): A state and locally funded program to assist with the cost of care in a licensed Adult Living Facility.	**Aged:** Individuals who are aged 65 and older. **Blind:** Individuals who are statutorily blind. **Disabled:** Individuals who are unable to perform any substantial gainful activity by reasons of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

Resource Methodologies

Resource methodologies are the ways in which various types of real and personal property are evaluated to determine whether an applicant owns "countable" resource equal to the resource standard. They are usually related to one of the federal cash assistance programs, AFDC or SSI. States may choose to evaluate resources in the same way as the federal programs or differently. They may impose more liberal methodologies for treating resources, and for the aged, blind and disabled, may impose more restrictive ones.

209(b) Option

Section 209(b) of P.L. 92-603 (which subsequently became Section 1902(f) of the *Social Security Act*) gives states the option of imposing more restrictive eligibility criteria on the aged, blind and disabled than the criteria imposed by the Supplemental Security Income (SSI) program. The authority, given to the states in 1972 when SSI was created in order to help those states whose eligibility criteria for the Aid to the Blind, Aid to the Permanently and Totally Disabled and Aid to the Aged programs had been lower than the national eligibility standards for the new SSI program, gave states the flexibility to set eligibility criteria no more restrictive than those set by the state Medicaid program on January 1, 1972. This option provided an alternative to mandating Medicaid eligibility for all SSI eligibles that would have resulted in additional expenditures of state funds for the cost of Medicaid. Virginia is one of 12 states who currently exercise the option, the other states being Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Carolina, North Dakota, Ohio, and Oklahoma.

A state may add or delete more restrictive criteria as its needs change without losing its 209(b) status. In addition, a state may choose to cover all SSI eligible individuals. If it chooses to do so, it may contract with the Social Security Administration under Section 1634 of the *Social Security Act* to determine Medicaid eligibility. In this instance, the applicant for SSI does not have to file a separate application for Medicaid. The states, however, have no input or control over the decisions of the Social Security Administration in designing eligibility criteria for SSI, thereby reducing the state's ability to anticipate or control additional Medicaid expenditures resulting from SSI changes.

The 209(b) option has been used in Virginia to contain Medicaid expenditures in selected areas of eligibility criteria when changes in the criteria for SSI would have caused large additional expenditures for Medicaid. The more restrictive criteria have been concentrated on the manner in which resources are evaluated, with the criteria discussed most often being the limit on the amount of exempted property contiguous to the applicant's home. SSI exempts the home and all contiguous property regardless of value; Virginia Medicaid exempts the home, the lot on which it sits regardless of value, and up to $5,000 in additional contiguous property. Other more restrictive criteria include: prohibiting presumptive eligibility or conditional eligibility; prohibiting presumptive disability; counting the value of interests in undivided estates; and limiting the time a home is exempt for individuals in nursing homes to six months from admission.

Eligibility Determination

Eligibility for Medicaid assistance is generally determined by eligibility workers assigned to one of the local Departments of Social Services throughout the Commonwealth under an inter-agency agreement between DMAS and the Department of Social Services. Other eligibility is determined by the Departments of Rehabilitative Services; Health; and Mental Health, Mental Retardation and Substance Abuse Services under support agreements with DMAS.

Mandatory Services

As with all state Medicaid programs, certain services provided by Virginia's program are mandated by the federal government. These are:

- Inpatient Hospital Services
- Emergency Hospital Services
- Outpatient Hospital Services
- Nursing Facility Care
- Rural Health Clinic Services
- Federally Qualified Health Center Clinic Services
- Laboratory and X-ray Services
- Physician Services
- Home Health Services: Nurse, Aide, Supplies and Treatment Services
- Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)
- Family Planning Services and Supplies
- Nurse-Midwife Services
- Medicare Premiums: Hospital Insurance (Part A)
- Medicare Premiums: Supplemental Medical Insurance (Part B) for the Categorically Needy
- Transportation Services

Optional Services That Are Provided

In addition to the federally-mandated services categories set forth above, Virginia has elected to provide services in the following major optional categories:

- Other Clinic Services (i.e., services provided by rehabilitation agencies, ambulatory surgical centers, renal dialysis clinics and local health departments)
- Skilled Nursing Facility Services for Persons Under 21 Years of Age
- Podiatrist Services
- Optometrist Services
- Clinical Psychologist Services
- Certified Pediatric Nurse and Family Nurse Practitioner Services
- Home Health Services: Physical Therapy, Occupational Therapy and Speech Therapy
- Dental Services for Individuals Under 21 Years of Age
- Physical Therapy and Related Services
- Prescribed Drugs
- Case Management Services
- Prosthetic Devices

Optional Services That Are Provided (Continued)

- Mental Health Services, including intensive in-home services for children and adolescents, therapeutic day treatment for children and adolescents, day treatment/partial hospitalization, psychosocial rehabilitation, crisis intervention and case management
- Community Mental Retardation Services, including day health rehabilitation services and case management
- Mental Health Clinic Services
- Intermediate Care Facility - Mental Retardation Services
- Home and Community-Based Care Waiver Services, including personal care services, adult day health care services, respite care services, private duty nursing services, case management services, mental retardation services, and services for the developmentally disabled.
- Hospice Services
- Medicare Premiums: Supplemental Medical Insurance (Part B) for the Medically Needy

Optional Services That Are Not Provided

The services listed below are generally not covered under Virginia's State Plan. Circumstances of partial coverage are noted. In addition, any of the non-covered services may be covered for children under age 21 if the need for the treatment is identified through an EPSDT screening.

- Chiropractor Services: Services are covered for QMBs, co-insurance and deductibles only.
- Private Duty Nursing Services: Services are covered only for technology-assisted children and individuals with AIDS/ARC under the appropriate waiver.
- Dentures
- Diagnostic Services: Services may be covered when part of another service.
- Screening Services: Mammograms are covered for women over age 35.
- Preventive Services: Services are covered for children under EPSDT.
- Inpatient Psychiatric Facility Services for Children Under Age 21: Services may be obtained under EPSDT.
- Ambulatory Prenatal Care for Pregnant Women Furnished During a Presumptive Eligibility Period by a Qualified Provider: Services to this group are offered once ongoing eligibility is established.
- Respiratory Care Services: Home respiratory equipment is covered under DME.
- Personal Care Services: Services are covered under a waiver.
- Cosmetic Procedures
- Experimental Procedures or Treatment

Description of Individual Covered Services

The services covered by Virginia Medicaid are described in detail on the following pages.

Inpatient Hospital Services: Acute care services that are ordinarily furnished to an individual in an inpatient hospital setting for the care and treatment of a condition or disease.

Date Services First Covered: 1969

Exclusions From Coverage	Limits On Coverage	Co-Payments Required	Required Pre-Authorization	Reimbursement Method
• Medically Needy patients 65 or over in institutions for mental disease. • Surgery when procedure can be done on an outpatient basis unless medically justified. • Organ transplants except for liver, heart, lungs, kidneys, corneas, bone marrow/stem cell for breast cancer, myeloma lymphoma, and leukemia and non-experimental transplants as required under EPSDT. • Private duty nursing. • Alcohol and drug rehabilitation. • Any services not medically necessary to treat a disease or condition.	• 21-day cap on length-of-stay for adults for those services not governed under a prospective, case-based payment methodology (i.e., Diagnosis-Related Group).	• Categorically and Medically Needy adult recipients must pay $100 directly to the hospital for each non-emergency admission, except for overnight admissions for renal dialysis. • No co-payment is required for children, pregnancy-related services, emergency services or for individuals receiving long-term care services.	• All transplants except corneas and kidneys. • All inpatient hospitalization, except those individuals that are determined eligible for emergency services for non-resident aliens.	• Reimbursement rates for most inpatient services based on a Diagnosis Related Groups (DRG) methodology. • Transition period established. • DRG system will be recalibrated (evaluation and adjustment of weights assigned to cases) and rebased (review and updating as appropriate of the cost basis on which the base rate is developed) at least every other year. • As regulations to implement the new reimbursement methodology are developed, DMAS will consult with affected provider groups in accordance with Item 322 of Chapter 912 (the Appropriations Act). (See note.)

Note: Chapter 912 also requires the DMAS Director to appoint a Medicaid Hospital Payment Policy Advisory Council to develop recommendations to the Board of Medical Assistance Services on such issues as: update/inflation factors, incorporation of capital and medical education costs, rebasing/recalibration mechanisms, and timing/final design of outpatient prospective payment systems. The Advisory Council shall include four hospital/health system representatives nominated by the Virginia Hospital and Healthcare Association, two senior Department staff, and one representative each from the Department of Planning and Budget and the Joint Commission on Health Care.

Outpatient Hospital Services: Diagnostic, therapeutic, rehabilitative or palliative services provided in an outpatient hospital setting and ordered and provided under the direction of a physician or dentist.

Date Services First Covered: 1969

Exclusions From Coverage	Limits On Coverage	Co-Payments Required	Required Pre-Authorization	Reimbursement Method
• Routine physicals and immunizations if patient is over 21. • Telephone consultations. • Artificial insemination or in-vitro fertilization. • Services not provided under the direction of a physician or dentist, except for nurse-midwife services.		• Categorically and Medically Needy adult recipients must pay $3.00 directly to the hospital for each non-emergency outpatient visit. • No co-payment is required from Medicaid recipients who are under 21 years of age, recipients who are seeking treatment for pregnancy-related services, and recipients who are seeking emergency treatment.		• Outpatient services are reimbursed on a cost-based retrospective method of payment. • Adoption of an Ambulatory Patient Groups (APG) methodology will occur sometime in the future. Chapter 912 requires the Medicaid Hospital Payment Policy Advisory Council to develop recommendation for the Board of Medical Assistance Services regarding the timing/final design of outpatient prospective payment services.

Physician Services: Services provided to a client by or under the supervision of a physician within the scope of medicine, osteopathy or psychiatry.

Date Services First Covered: 1969

Exclusions From Coverage	Limits On Coverage	Co-Payments Required	Required Pre-Authorization	Reimbursement Method
• Elective surgery not medically necessary to restore or materially improve a body function. • Elective surgery that has not been pre-authorized. • Cosmetic surgery not required for psychological reasons. • Cosmetic surgery that has not been pre-authorized. • Experimental procedures. • Transplant surgery except for heart, lung, liver, kidneys, corneas, bone marrow/ stem cell for breast cancer, lymphoma, myeloma and leukemia and those required under the EPSDT program. • Inpatient surgery that could be performed on an outpatient basis. • Routine physicals and immunizations not covered under EPSDT.	• Individual psychotherapy limited to 5 sessions without pre-authorization. • Psychiatric sessions cannot exceed 3 within 7 days. • Comprehensive office visits limited to 1 annually. • Extended office visits limited to 1 annually. • Pap smears limited to 1 every 6 months. • House calls limited to patients who are bedridden and for whom a trip to a physician's office is inadvisable. • Nursing home visits limited to 1 per month. • Sterilizations limited to those over 21 years of age, who are mentally competent and who give advanced informed consent. • Surgery for morbid obesity under limited conditions.	• Categorically and Medically Needy adult recipients must pay $1.00 directly to the physician for each office visit for non-emergency treatment. • Categorically and Medically Needy adult recipients must pay $3.00 directly to the physician for each inpatient hospital visit. • No co-payment is required for children, pregnancy-related services, emergency services, individuals who are residents of hospice, nursing homes, ICF for mentally retarded, or mental hospitals.	• Elective surgery. • Cosmetic surgery. • Individual psychotherapy above 5 sessions. • Individual consideration may be requested if the physician feels that there is medical justification for coverage differing from that set forth in the exclusions. • Procedure Codes listed for prior authorization in Chapter IV of Physician's Provider Manual.	• Fee-for-service reimbursement. Payment is based on the lower of the program's fee schedule or actual charge. • Organ transplants (except for corneas and kidneys) reimbursed at the actual facility charges if less than flat fee or percentage of charges specific to the type of transplant. Whichever is greater.

Nursing Facility Services: Services provided by a nursing facility to a client who needs care on a daily basis. Persons seeking admission to a nursing facility are screened by Medicaid to determine the medical need or the potential for placement in an alternative community-based care program. While the number of nursing facility days is not limited, a patient's condition is reviewed periodically to determine the continuing need and appropriate level of care. Effective October 1, 1990, the classifications for the two levels of care in nursing facilities (skilled and intermediate) were eliminated by the Omnibus Budget Reconciliation Act of 1987, and nursing facility care was made a mandatory service. In July 2002, DMAS implemented a revised methodology entitled "Resource Utilization Groups" or RUGS for reimbursing providers of nursing facility care. RUGS is a patient-based methodology which links a nursing facility's per diem rate for direct patient care operating expenses to the intensity of services required by a nursing facility's patient mix. DMAS also reimburses nursing facility providers, who have an additional provider agreement, for specialized care services. The specialized care program is designed to include those recipients with very specific and complex medical and nursing needs. The services covered under the specialized care program include the following categories: ventilator ,complex care, and intensive rehabilitation; though complex care and intensive rehabilitation are now limited to children residing in nursing facilities. This program is designed to serve as a step down from acute care services.

Date Services First Covered: 1969. Coverage of Nursing Facility Services was not mandated by the federal government until October 1, 1990. Skilled Nursing Facility Services for persons under 21 years of age are non-mandated services, but are covered by Virginia except for patients in institutions for mental diseases.

Exclusions From Coverage	Limits On Coverage	Patient Payment Required	Required Pre-Authorization	Reimbursement Method
• All patients under age 65 in institutions for mental diseases. • Medically Needy patients 65 or older in institutions for mental diseases.	• Payment may be made for reserving a bed for a nursing home patient for up to 18 days per year for temporary leaves of absence for any reason other than an inpatient hospital admission. • Access to return from hospital admissions is guaranteed.	• Patient payment to nursing home of all monthly income after a personal allowance and other allowable deductions are subtracted. Medicaid will pay the remainder of allowable costs up to the maximum limit.	• Admission must be approved by a local Health Department Nursing Home Pre-Admission Screening Committee in conjunction with the local Department of Social Services, or Hospital Nursing Home Pre-Admission Screening Committee (if the recipient is hospitalized).	• A prospective rate for operating costs is determined for each facility in accordance with Medicaid reimbursement principles. Allowable direct and indirect operating costs are limited by ceilings and charges. Allowable direct costs and operating cost ceilings are adjusted by the facility's case-mix index (CMI) for its patients (see above). • A prospective rate is also determined for allowable plant costs (depreciation, interest, debt financing, rent and lease costs,

				etc.) in accordance with Medicaid reimbursement principles.

Home Health Services: Health care and/or short term services provided to clients in their residences under a plan of treatment written by the patient's attending physician. Services may include nursing care (mandated), physical therapy (optional), occupational therapy (optional) and speech-language pathology (optional) services. Durable medical equipment and supplies (mandated) are available to home health recipients based upon a physician's plan of care.

Date Services First Covered: 1969.

Exclusions From Coverage	Limits On Coverage	Co-Payments Required	Required Pre-Authorization	Reimbursement Method
• Duplicative home health aide. • Medical social services. • Services and items not covered for inpatient treatment. • Food service. • Domestic/housekeeping services unrelated to care. • Custodial care. • Cosmetic surgery related services. • Certain supplies and equipment.	• Skilled nursing visits limited to 32 per year. Extensions may be granted if medically necessary. • Home health aide visits limited to 5 per year without pre-authorization. No extensions permitted. • Physical therapy, occupational therapy and speech therapy limited to 5 visits per year without prior authorization. Extensions may be granted if medically necessary.	• Categorically Needy and Medically Needy recipients pay a $3.00 per visit co-payment directly to the providing agency.	• Pre-authorization required to exceed visit limits listed in second column. • Pre-authorization required for home renal dialysis equipment.	• Payment for nursing and aide services is based on a per-visit fee schedule. The rate per visit is adjusted annually based on the percentage of change in the moving average of DRI national forecast tables for the Home Health Agency Market Basket. • Payment for supplies and equipment is the lower of the program's fee schedule, actual charge or Medicare allowance.

Related Services: Physical therapy, occupational therapy and speech therapy services are non-mandated services, but are covered by Virginia.

Dental Health Services: The basic elements of dental care necessary for good health are provided for eligible clients who are younger than 21 years of age. These include restorations, emergency services and extractions for the relief of pain and elimination of infection, and preventative services and treatment such as X-rays, cleaning and fluoride applications. High cost procedures, including complete dentures, partials and permanent bridgework, are covered through prior authorization.

Date Services First Covered: 1973.

Exclusions From Coverage	Limits On Coverage	Co-Payments Required	Required Pre-Authorization	Reimbursement Method
• Services for adults except for limited oral surgery. • Bleaching of teeth. • Pulp vitality tests. • Occlusal adjustments. • Gingival curettage. • Cavity liners and intermediate bases under restorations. • Prescriptions, biologicals and supplies. • Local anesthesia.	• Services are generally limited to recipients under age 21. • Services include emergency services for relief of pain and infection, preventive treatment, routine therapeutic services and other diagnostic services. • Limits based on dental necessity and/or utilization control such as the following. • Once every 6 months: Examinations, prophylaxis, fluoride treatment. • Once every 12 months: Space maintainers, Bitewing x-rays. • Once every 3 years: Routine amalgam and composite restorations. • Once every 5 years: Dental prothetics. • One time limitation: Extractions, orthodontics, tooth guidance appliances, and endodontics.	• None.	• Oral surgery for all recipients age 21 and older. • Specialized dental services to EPSDT recipients. • High cost services such as orthodontics, endodontics, crowns and dentures for clients under age 21.	• The lower of the program's fee schedule, actual charge.

Laboratory and X-ray Services: Professional and technical laboratory and radiological services are covered when ordered by a physician or dentist. The services may be provided in an office of a physician or dentist, certified independent laboratory, or in a laboratory of the Department of Health or local health department.

Date Services First Covered: 1969.

Exclusions From Coverage	Limits On Coverage	Co-Payments Required	Required Pre-Authorization	Reimbursement Method
• Sensitivity studies when a culture growth shows no growth. • Urine cultures with containment growth. • Syphilis testing. • Forensic tests.	• Services must be ordered by a physician or dentist.	• None.	• Not required.	• The lower of the program's fee schedule, actual charge or Medicare allowance.

Family Planning Services: These services include consultation, examination, treatment, drugs, medically-approved methods and devices to prevent conception, and voluntary sterilizations for women and are available to clients of child-bearing age. Most family planning services qualify for Federal Financial Participation at 90 percent. However, FFP at the 90 percent rate is not available for hysterectomies and other procedures for medical reasons, nor is it available for transportation to a family planning service.

Date Services First Covered: 1969.

Exclusions From Coverage	Limits On Coverage	Co-Payments Required	Required Pre-Authorization	Reimbursement Method
• Services or drugs to treat or promote fertility.	• Services must be prescribed by a physician. • Family Planning	• None.	• Not required.	• Payment is made according to type of service rendered (*i.e.,* prescribed drugs, physician services, etc.)

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services: EPSDT screening services refer to those screening and diagnosis services used to determine physical or mental problems in clients who are less than 21 years of age. Health care treatment and other measures are provided to correct or improve any problems and chronic conditions discovered. Services include health and developmental history screening, immunizations, nutritional status assessment, vision and hearing testing, dental services for children three years and older, and visual treatment including eyeglasses. Local Departments of Social Services are required to inform eligible individuals of the EPSDT Program's availability, but participation by recipients is voluntary.

As originally mandated by Congress in 1967, EPSDT was a preventative health care program for children. Each state was required to provide periodic health screenings for children under the age of 21 who were eligible for Medicaid under any eligibility category. (Most of the eligible children were AFDC recipients.) The screenings included an unclothed physical examination, a health history, vision and hearing assessments, age appropriate immunizations, minimal laboratory tests and annual referral to a dentist starting at age 3. If a health problem was detected during the screening examination, the physician was required to refer the child for treatment. However, Medicaid was not mandated to cover any treatment outside the range of services already covered by Virginia's State Plan.

OBRA '89 significantly expanded both the eligibility for EPSDT and the services that were covered. OBRA '89 also added a few new services such as lead testing and parent education, but the most significant change was that treatment for conditions found during a screen must now be provided by Medicaid, *whether or not this treatment is covered by the State Plan.* For example, a child found to have scoliosis (curvature of the spine) on a regular exam may need a special back brace. Braces are not normally covered by Medicaid but will be in this case because the child is eligible through EPSDT.

Date Services First Covered: 1969.

Exclusions From Coverage	Limits On Coverage	Co-Payments Required	Required Pre-Authorization	Reimbursement Method
• Individuals who are 21 years old or older.	• Children from birth to 21 years of age are entitled to 20 periodic examinations. • Services are provided in excess of federal requirements.	• No co-payment for services to children.	• Prior authorization is required for services not covered under Virginia's State Plan and for services which require pre-authorization as part of the State Plan.	• Screenings are paid on a fee-for-service basis. • Payment for other services is made according to the type of service rendered.

Nurse Midwife Services: These services involve the management of the care of mothers and newborns throughout the maternity cycle, which is defined as the period covering pregnancy, labor, birth and up to a maximum of six weeks postpartum. Nurse midwives are enrolled directly by Medicaid, but Virginia's licensing laws require that they be supervised by a licensed physician.

Date Services First Covered: 1985.

Exclusions From Coverage	Limits On Coverage	Co-Payments Required	Required Pre-Authorization	Reimbursement Method
• Services are subject to state licensure requirements.	• Not applicable.	• No co-payment for pregnancy-related services.	• Not required.	• The lower of the program's fee schedule, actual charge or Medicare allowance.

Rural Health Clinic Services: These are preventative, diagnostic, therapeutic, rehabilitative, or palliative items or services provided to clients on an outpatient basis under the direction of a specifically trained primary care practitioner (typically called physician assistants and nurse practitioners) by a facility that is not part of a hospital, but is specifically designated as a Rural Health Center in accordance with the *Rural Health Clinic Services Act of 1977*. The intent of this act is to increase the availability of primary and emergency care services in medically underserved rural communities.

Date Services First Covered: 1978.

Exclusions From Coverage	Limits On Coverage	Co-Payments Required	Required Pre-Authorization	Reimbursement Method
• Same exclusions as Outpatient Hospital, except services do not necessarily have to be provided under the direction of a physician or dentist.	• Not applicable.	• Categorically Needy and Medically Needy recipients pay a $1.00 per visit co-payment directly to the Rural Health Clinic.	• Not required.	• Payment is based on retrospective cost reimbursement principles.

Federally Qualified Health Center Services: These are preventative, diagnostic, therapeutic, rehabilitative, or palliative items or services provided to clients on an outpatient basis under the direction of a specifically trained primary care practitioner (typically called physician assistants and nurse practitioners) by a facility that is not part of a hospital, but is specifically designated as a Federally Qualified Health Center in accordance with the *Public Health Services Act*. FQHCs are more commonly known as community health centers, migrant health centers, and health care for the homeless programs.

Date Services First Covered: April 1, 1990.

Exclusions From Coverage	Limits On Coverage	Co-Payments Required	Required Pre-Authorization	Reimbursement Method
• Same exclusions as Outpatient Hospital, except services do not necessarily have to be provided under the direction of a physician or dentist.	• Not applicable.	• Categorically Needy and Medically Needy recipients pay a $1.00 per visit co-payment directly to the Federally Qualified Health Center.	• Not required.	• Payment is based on retrospective cost reimbursement principles.

Payment of Medicare Premiums: Medicaid pays the Part A (hospital insurance) and Part B (voluntary supplementary medical insurance) Medicare Premiums, deductibles and co-payments for certain categories of individuals eligible for both Medicaid and Medicare. These categories and the various payments that are made on their behalf are set forth in more detail in the report entitled “Medicare/Medicaid Dual Eligibles” contained in Section 12 of this publication.

Exclusions From Coverage	Limits On Coverage	Co-Payments Required	Required Pre-Authorization	Reimbursement Method
• Individuals who do not qualify for Medicare coverage.	• Part A coverage limited to QMBs and QDWIs. • Part B coverage provided to QMBs, non-QMBs (medically needy individuals who have to spend down to qualify for Medicaid), SLMBs, QI1s, and QI2s (partial payment). • Individuals must enroll for Part A coverage during an annual open enroll-ment period (January 1 - March 31), or during the initial enrollment period.			• Premiums are determined by CMS for a 12-month period and become effective on January 1 each year. Rates are published in the *Federal Register.* • DMAS exchanges computer tapes with CMS on a monthly basis to identify Medicare-covered Medicaid-eligible individuals.

Mental Retardation Services in General: These services are provided to persons with mental retardation. Such individuals require special care and services to achieve their potential. Persons with mental retardation have significant sub-average intellectual functioning accompanied by deficiencies in skills such as self-care and independent living.

Most persons with mental retardation are able to live in community-based homes with their families or other persons who can offer assistance. These persons can generally participate in daytime activities, including programs that offer training ranging from self-help habilitation programs to supported employment programs. However, some persons require more intensive services, and some of these most severely impaired persons are served in large Medicaid-certified residential institutions known as intermediate care facilities for the mentally retarded (ICFs/MR). These facilities provide 24-hour care and range in size from private facilities of 15 beds or fewer to very large state-operated institutions of over 1,000 beds.

Intermediate Care Facility - Mental Retardation Services: These services are provided by a facility or distinct part of another facility in which the primary purpose is to provide health or rehabilitative services for mentally retarded persons, or persons with related conditions, and which is certified by the Department of Health as meeting the federal certification regulations for an ICF/MR. These facilities must address the total needs of the resident, including physical, intellectual, social, emotional and habilitation needs, and provide active treatment. "Active treatment" consists of an aggressive, structured, individualized, and professionally supervised program based on measurable goals to help the resident function at the highest level possible.

Date Services First Covered: 1972.

Exclusions From Coverage	Limits On Coverage	Co-Payments Required	Required Pre-Authorization	Reimbursement Method
• Medically Needy recipients are not covered.	• Limited to medically necessary care and services.	• Not applicable.	• Applicants are reviewed and must meet ICF/MR criteria as defined in the *Virginia State Plan for Medical Assistance* in order to receive Medicaid-funded ICF/MR services.	• Mental retardation facilities are reimbursed their allowable Medicaid costs based on a retrospective reimbursement method.

Mental Hospital Services for the Aged (65 Years and Older): These services are provided in an "institution for mental disease (IMD)" which is defined as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care, and related services." Under federal regulations, Medicaid covers these services for individuals who are 65 years of age or older. Medicaid regulations indicate that the classification of an institution as an IMD, rather than as an ordinary provider, "is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such." The determination of a facility's "overall character" has been a source of controversy between the federal government and the states.

Date Services First Covered: 1972.

Inpatient Psychiatric Hospital Services for Individuals Under 21 Years of Age: A psychiatric hospital must meet Medicare conditions of participation. Prior to 1984, this meant that it had to be specifically certified as a psychiatric facility by the Joint Commission on Accreditation of Hospitals. This requirement was deleted from Medicare law by the *Deficit Reduction Act of 1984 (P.L. 98-369*), but has been retained in Medicaid regulations. Beneficiaries receiving inpatient psychiatric hospital services must be undergoing active treatment, in accordance with an individual plan of care, intended to "improve the recipient's condition or prevent further regression so that the services will no longer be needed." Under federal Medicaid regulations, these services may be covered only for beneficiaries age 21 and under; however, beneficiaries who are under 21 at the time they enter such a facility may continue receiving care until they reach 22. Payment is limited to the cost of care billed by the psychiatric hospital. No other services are covered.

Date Services First Covered: Inpatient psychiatric services for beneficiaries age 21 and under covered through EPSDT requirements which became effective in 1989.

Exclusions From Coverage	Limits On Coverage	Co-Payments Required	Required Pre-Authorization	Reimbursement Method
• Medically Needy recipients are not covered. • Persons between 21 and 65 years of age are not provided services (see note below).	• Limited to medically necessary care and services.	• Not applicable.	• EPSDT Screening must be performed by provider. • Community Services Board (CSB) must provide a certificate of need for inpatient services. • Admission and continued length of stay must be approved by DMAS.	• Facilities are reimbursed their allowable Medicaid costs based on a retrospective reimbursement method.

Note: The effect of the rules for the two types of institutional mental health providers is to exclude Medicaid coverage of services in mental institutions for persons between 21 and 65 years old. Beneficiaries between age 21 and 65 may receive services for mental illness in general hospitals and nursing facilities, but only if those facilities are not IMDs.

Services for Persons with Mental Illness: Medicaid is an important source of funding for the treatment of mental illness, including long-term serious mental illness and short-term acute problems. Medicaid provides outpatient services, in-patient services and community-based mental health rehabilitative services to individuals who meet the specified criteria for each service.

The following is a summary of the mental health and mental retardation services covered by Virginia Medicaid as of July 1, 1998.

Type of Service	Specific Services Covered	Population Covered	Limitations
Outpatient Services	Psychiatric Services	All Medicaid eligibles	Service limited to an initial availability of 5 sessions of medical psychotherapy, with one possible extension of 5 sessions during the first year of treatment and an additional 5 sessions per year available upon authorization by DMAS.
	Psychological Testing	All Medicaid eligibles	Covered when it is related to an apparent or diagnosed psychiatric illness and is part of the physician's plan for the diagnosis and treatment of a mental illness or disease. Testing is allowed once per year unless initial diagnosis is inaccurate or highly suspected to have changed.
Inpatient Services	Inpatient Service Through EPSDT	Medicaid eligibles under age 21	Individuals under age 21 who have been identified by a physician as having a condition of mental illness which can be ameliorated or corrected through inpatient psychiatric services.
	Short-Term Inpatient Services	All Medicaid eligibles	Covered in general hospitals when certified by the hospitals' utilization review committees and prior authorization by DMAS.
	Long-Term Services	Medicaid eligibles age 65 and over	Covered for individuals 65 years of age or over and only in facilities for mental diseases that have been certified by the state agency.
Community Mental Health Rehabilitative Services	Intensive In-Home Services for Children and Adolescents	Medicaid-eligible children and adolescents	One hour of service. A maximum of 26 weeks of intensive in-home service may be offered per year.
	Therapeutic Day Treatment for Children and Adolescents	Medicaid-eligible children and adolescents	A maximum of 780 units of Therapeutic Day Treatment services may be offered per year. One unit of service is defined as a minimum of two but less than three hours in a given day. Two units are defined as at least three but less than five hours. Three units is defined as five or more hours on a given day.

Type of Service	Specific Services Covered	Population Covered	Limitations
Community Mental Health Rehabilitative Services (continued)	Day Treatment/Partial Hospitalization	Medicaid-eligible adults	A maximum of 780 units of Day Treatment/Partial Hospitalization may be offered per year. One unit of service is defined as a minimum of two but less than four hours in a given day. Two units are defined as at least four but less than seven hours. Three units are defined as seven or more hours on a given day.
	Psychosocial Rehabilitation	All Medicaid eligible adults (See Chapter 4 of Provider's Manual)	A maximum of 936 units of service may be offered per year. One unit of service is a minimum of two hours but less than four hours on a given day. Two units of service are at least four hours but less than seven hours. Three units of service are seven or more hours on a given day.
	Crisis Intervention	All Medicaid eligibles	One unit of service is 15 minutes of Crisis Intervention. A maximum of 720 units of Crisis Intervention can be provided annually.
	Case Management	Medicaid-eligible children with serious emotional disturbance (SED), Youth at risk of serious emotional disturbance, and Individuals with serious mental illness (SMI).	The unit for case management is a month. To bill for case management, a contact must be made. Reimbursement is provided only for "active" case management consumers. There is no maximum service limit for case management services except for services provided to individuals residing in institutions or medical facilities. (See Chapter 4 of Provider's Manual) Case management may not be billed for the same individual by any more than one type of case management provider.
	Intensive Community Treatment	Medicaid eligible adults with serious mental illnesses (SMI)	An hour is one unit of service. There is a limit of 130 units annually.
	Crisis Stabilization	All Medicaid eligibles	An hour is one unit of service. There is a limit of eight (8) hours per day for up to 15 consecutive days in each episode, up to 60 days annually.
	Mental Health Supports	All Medicaid eligibles	One unit is at least one hour but less than 3 hours. Two units is at least 3 but less than 5 hours. Three units is at least 5 but less than 7 hours. Four units is 7 hours or more. There is a limit of 31 units per month.
	Substance Abuse Residential Treatment for Pregnant Women	Medicaid eligible pregnant and post-partum women	Billing unit is 1 day. There is a limit of 330 days of continuous treatment, not to exceed 60 days post partum. Unauthorized absence of 72 hours is included in this limit.
	Substance Abuse Day Treatment for Pregnant Women	Medicaid eligible pregnant and post-partum women	Billing unit is at least 2 hours but less than 4 hours on a given day. Two units is at least 4 hours, but less than 7 hours. Three units is 7 or more hours. There is a limit of 440 units in a 12 month consecutive period, one in a

			lifetime, not to exceed 60 days postpartum.

Type of Service	Specific Services Covered	Population Covered	Limitations
Community Mental Retardation Services	Case Management Services	All Medicaid eligibles with MR	Reimbursement is provided only for "active" case management consumers. A unit of service is equal to a month of service. Billing can be submitted only for months in which direct or consumer-related contacts, activity or communication occur. There is no maximum service limit except for individuals residing in institutions, medical facilities or ICF/MR Group Homes. (See Chapter 4 of Community Mental Retardation Services manual)
Mental Retardation Waiver Services	In-Home Residential	Individuals who meet the level of care criteria for ICF/MR but whose needs can be met through a combination of home and community-based services in lieu of institutional services	The amount and type of Residential Support Services which can be authorized are determined by the consumer's assessed support needs, the Consumer Service Plan (CSP) and residential Individual Service Plan. The service must be provided at a frequency that allows for functional support to be in place. Medicaid Waiver reimbursement is available only for those hours of Residential Support Services provided when the consumer is present. The service is reimbursed on an hourly basis for the time the residential support aide is in the home working with the consumer. Total monthly billing cannot exceed the total authorized hours per month based on the Service Authorization Form (DMHMRSAS-229).
	Residential Support	Same as above	The services are reimbursed based on an average daily number of hours, which is established for each consumer from the total authorized hours per month on the CSP (based upon careful estimates of need/historical plan date) divided by 30 (the average number of days in a month). The total monthly billing cannot exceed the total authorized hours per month based on the Service Authorization Form (DMHMRSAS-229).
	Personal Assistance Services	Same as above	This service is designed to assist individuals with the Activities of Daily Living (ADL). Personal Assistance cannot be offered to an individual who receives Assisted Living Services in an Adult Care Residence.
	Respite Care Services	Same as above	The unit of service for Respite Care Services is one hour. The service provided in any setting shall be limited to 720 hours or 30 days per calendar year. The year begins on the first day of authorized services.

Type of Service	Specific Services Covered	Population Covered	Limitations
Mental Retardation Waiver Services (Continued)	Nursing Services	Same as above	The unit of service is one hour. There is no limitation on the number of hours of Nursing Services that may be authorized. However, these services are rendered according to a plan of care authorized by DMHMRSAS and certified by a physician as medically necessary to enable the individual to remain in the community rather than in a ICF/MR.
	Environmental Modifications	Same as above	The maximum expenditure for modifications are $5,000 per year. The service unit for Rehabilitation Engineering and Building contractors is hourly. Supplies are reimbursed at their cost.
	Assistive Technology	Same as above	The maximum expenditure for assistive technology are $5,000 per year. The service unit for Rehabilitation Engineering and Building contractors is hourly. Supplies are reimbursed at their cost.
	Day Support Services	Same as above	Services may be provided for a maximum of 780 units per year. One unit of service is 1 to 3.99 hours of service a day, including transportation. Two units are 4 to 6.99 hours of service a day, including transportation and three units are seven or more hours of service a day, not including transportation of the consumer. The plan of care must provide an estimate of the amount of Supported Employment Services required by the consumer. The amount and type of Day Support Services included in the consumer's plan of care is determined according to the level of staff involvement required for the consumer. The service may be provided at either Intensive or Regular Levels. To be authorized at the Intensive Care Level, the consumer must meet at least one of the following criteria: • Requires physical assistance to meet the basic personal care needs of toileting, feeding, etc. • Has intensive disability-related difficulties and requires additional, ongoing support to fully participate in programming and to accomplish individual service goal. • Requires extensive personal care and/or constant supervision to reduce or eliminate behaviors which preclude full participation in programming. A formal written behavioral program is required to address

			behaviors such as severe depression, self-injury or self-stimulation.

Type of Service	Specific Services Covered	Population Covered	Limitations
Mental Retardation Waiver Services (Continued)	Supported Employment Services	Same as above	Service providers are reimbursed only for the amount and type of Supported Employment Services included in an individual's approved Individual Service Plan (ISP) based on an hourly fee-for-service. With the individual job placement model of supported employment, reimbursement shall be limited to actual documented interventions or collateral contacts by the providers. Individual job placement must be billed on an hourly basis. Group models of Supported Employment Services must be billed at the unit rate. One unit is 1 to 3.99 hours of service a day, including transportation. Two units are 4 to 6.99 hours of service a day, including transportation and three units are seven or more hours of service a day, not including transportation of the consumer. The plan must provide an estimate of the amount of Supported Employment Service required by the consumer.
	Therapeutic Consultation Services	Same as above	The unit of service is one hour. All therapeutic consultation services are reimbursed at a rate of $50.00 per hour. Travel time, written preparation, and telephone communication are in-kind expenses within this service and are not billable as separate items. Therapeutic Consultation may not be billed solely for purposes of monitoring.
	Personal Emergency Response Systems	Same as above	A unit of service shall include administrative costs, time, labor, and supplies associated with the installation, maintenance, and monitoring of the PERS. A unit of service is one-month rental price set by DMAS. The one time installation of the units(s) shall include installation, account activation, individual and caregiver instruction, and removal of equipment.
	Companion Services (Agency Directed)	Same as above	Available to adults only, age 18 or older. The services must be billed on an hourly basis. The amount of Companion services time included in the ISP may not exceed eight hours per 24-hour day. When two individuals in the same home request Companion services, the amount of time for tasks which could and should be provided for both individuals simultaneously must be combined with the hours split between the individuals.

Type of Service	Specific Services Covered	Population Covered	Limitations
Mental Retardation Waiver Services (Continued)	Companion Services (Consumer Directed)	Same as above	Must be billed on an hourly basis. The amount of Companion services time included in the ISP may not exceed eight hours per 24-hour day.
	Respite Services (Consumer Directed)	Same as above	Respite assistants are paid an hourly rate, and are paid by the fiscal agent on behalf of the individual. Respite care is limited to 720 hours per individual per calendar year. Those who receive CD- Respite and Agency-Directed Respite cannot receive more than 720 hours combined.
	Personal Assistance (Consumer Directed)	Same as above	May not be authorized for an individual who receives MR Waiver Congregate Residential Support or while living in a licensed Assisted Living Facility. May not be provided during the same billable hours as MR Waiver Supported Employment or Day Support. Limited exceptions may be requested of DMHMRSAS for individuals who require assistance in the workplace. Personal Assistants are paid an hourly rate by the fiscal agent on behalf of the individual. The individual's needs and required supports determine the amount of Personal Assistance services that can be authorized.
	Prevocational	Same as above	Are available only for persons whose compensation is less than 50% of minimum wage. Billing is for a unit of service: One unit is 1 to 3.99 hours of service a day, including transportation of the individual to and from the service site; Two units are 4 to 6.99 hours of service a day, including transportation of the individual to and from the service site; Three units are 7 or more hours of service a day. While transportation of the individual to and from the service site may be included, a minimum of 7 hours of other allowable activities must be provided in order to be reimbursed for a 3-unit day. The maximum is 780 units per CSP year.

Treatment Foster Care (TFC) Case Management Services: Treatment Foster Care Case Management is a program designed to address the special needs of children and their families when those needs can be met through services delivered primarily by treatment foster parents who receive training, supervision and support. It is a community-based treatment option grounded in the same values that have guided efforts to develop alternatives to the institutionalization of children with special needs. Treatment is primarily home-based, planned by a treatment foster care case manager and delivered by a treatment team that includes the treatment foster parents, the child's family members, specified agency staff and other professionals who continually interface to provide mutual support, evaluate treatment and revise the treatment plan as necessary. When possible, the children themselves also participate.

In addition to providing treatment for specific problems or conditions, TFC seeks to promote a permanent family living arrangement for the children it serves. A written treatment plan containing measurable goals, procedures and interventions for achieving them, and a process for assessing the results must be developed for each child served.

Date Services First Covered: Chapter 935 of the *1999 Virginia Acts of Assembly* requires DMAS to promulgate regulations to implement Medicaid reimbursement for TFC case management services designed to serve children and youth referred by local Comprehensive Services Act teams. CMS approved TFC for Medicaid reimbursement, and DMAS began payments for these services in March of 2000.

Pharmacy Services: Prescribed drugs are substances prescribed by a physician or licensed practitioner for the cure, mitigation, or prevention of diseases, or for health maintenance. Drugs must be dispensed by authorized pharmacies or dispensing physicians using a written prescription order, which is kept on record. Effective July 1, 2002, pharmacies are expected to seek payment from third-party payers before billing Medicaid.

Date Services First Covered: 1969.

Exclusions From Coverage	Limits On Coverage	Co-Payments Required	Required Pre-Authorization	Reimbursement Method
• Drugs for weight loss for non-institutionalized recipients unless prior authorization has been received. • Drugs used for anorexia or weight gain. • DESI drugs considered by the FDA to be less than effective. • Drugs which have been recalled. • Experimental or non-FDA approved drugs. • Drugs distributed or manufactured by drug manufacturers or labelers who have not agreed to participate in the Federal Drug Rebate Program (described below). • Drugs used to promote fertility. • Drugs used for cosmetic purposes, such as hair growth and skin depigmentation. • Vaccines for routine immunizations except under EPSDT which are covered under the federal vaccines for	• Limited to legend drugs except for: insulin, needles and syringes for diabetics; glucose test strips for children; family planning drugs and supplies; specific therapeutic categories of non-legend drugs for nursing home patients; and specific therapeutic categories of non-legend drugs for use by outpatients when used in lieu of more costly prescription products. • Prescriptions for multiple-source drugs are filled with generics unless the prescriber certifies a particular brand is medically necessary. • Sildenafil covered to a maximum of 4 doses in a 30 day period. Service limited to males over 21 years of age being treated for erectile dysfunction (ED). • Prescriptions are limited to dispensing maximum of 34 days supply at one time.	• Categorically Needy and Medically Needy recipients pay a co-payment directly to the dispensing pharmacy, except for family planning drugs or drugs used for pregnancy-related conditions. Additionally, persons under 21 years of age or patients residing in nursing facilities do not pay a co-payment. The co-payment varies depending on if it is a generic or brand drug. • Generic Drug co-pay = $1.00 • "Brand" drug co-pay = $3.00	• Pre-authorization is required for drugs when used for weight loss and will only be allowed when all requirements of the State Plan for such coverage are fulfilled.	• *Non-Nursing Home Pharmacies:* The lowest of the federal or state maximum allowable cost, average wholesale price (AWP) less a discount (currently AWP-10.25%), or the pharmacist's usual and customary charge. In addition, a once-monthly dispensing fee of $3.75 is paid for each product dispensed. • *Nursing Home Pharmacies:* Payment as described above, except the Program recognizes the 24-hour unit-dose delivery system of dispensing drugs for patients in nursing homes. Added packaging and handling costs are allowed. • Reimbursement for sole source drugs or branded products certified as medically necessary is the estimated acquisition cost, based on a discount to the AWP plus dispen-sing fee.

children’s program.				

Pharmacy Services (continued):

Exclusions From Coverage	Limits On Coverage	Co-Payments Required	Required Pre-Authorization	Reimbursement Method
				• Intravenous (IV) Therapy Service Day Rate for home therapy established July 1, 1998. Includes daily pharmacy service components for IV hydration, chemo-therapy, drug therapy, pain management and total parenteral nutrition (TPN). All active ingre-dients billed separately, using standard pharmacy billing forms. • Payment will be denied on any prescription claim which does not use the correct Medicaid prescriber's identification number. Denial may be overridden by inserting a correct prescriber identification number or 1 of 4 valid defaults established for unusual circumstances. Overutilization of defaults will be monitored.

Pharmacy Management Initiatives*:* Various initiatives to manage the Medicaid Prescription Benefit are underway in cooperation with the Medicaid Pharmacy Liaison Committee which is comprised of representation from the provider community and DMAS. These initiatives are focusing on the following aspects of the program:

Disease State Management (DSM): As it relates to pharmacy, this is the practice of monitoring patients' drug therapy and medical claims on an ongoing basis in relation to what is usually a long-term disease and intervening when necessary, with the goal of helping patients maintain or improve their health as much as possible. Disease targets include asthma/chronic obstructive pulmonary disease, diabetes, depression, hypertension/congestive heart failure and gastroesophageal reflux disease/peptic ulcer disease.

Pharmacy Services (continued):

- **Outcomes Management:** (a component of DSM) An approach to patient care that focuses on achieving the best possible end result of therapy in the most cost-effective way. It enables health care providers to examine the total costs of patient care as opposed to the component costs. For instance, greater patient compliance with drug therapy may raise a health plan's drug costs, but these costs may be offset because compliance with the therapy prevents the need for expensive emergency care at a hospital.

Drug Utilization Review (DUR): An examination of the medications a patient has been prescribed to make sure they are safe to take with other drugs the patient may be using. The examination may also consider other factors affecting a patient's use of a drug, including allergies and medical history.

- **Retrospective DUR (also referred to as RetroDUR):** A review of a patient's past drug therapy history and medical profile.

- **Concurrent DUR:** An examination of a patient's current use of multiple drugs.

- **Prospective DUR (also referred to as ProDUR):** A mechanism to improve the patient's quality of care, conserve program funds through the appropriate use of medications, maintain program integrity of quality system of patient care by review of patients' records before medications are dispensed (i.e., drug choices for a patient are pre-screened before a new one is used). Prospective DUR may be performed on-site (using pharmacy records of the provider) or on-line (as part of a Point-of-Service system). The DMAS-generated on-line ProDUR alerts are based on criteria established by the DMAS Drug Utilization Review Board (DUR Board). They (1) facilitate identification of therapeutically dangerous situations prior to dispensing, (2) evaluate therapy choices by prescribers and across pharmacies, (3) provide instantaneous monitoring, and (4) provide compliance with the OBRA '90 mandate that requires states to develop and adopt regulations for a DUR Program to ensure that prescriptions for outpatient drugs are appropriate, medically necessary and are not likely to cause adverse medical effects. Components of this program include:

    - **Early Refill:** When a prescription refill is requested before 75 percent of the calculated days' supply has elapsed for the previously filled prescription. The calculations are based on the pharmacist's entry of total days supply during the Point-of-Service submission process.

    - **Therapeutic Duplication Denial:** When there is concurrent use of two products in the same category, payment will be denied unless there is a manual intervention. Categories targeted include ACE Inhibitors, Antidepressants, Antiulcer, Benzodiazepines, Calcium Channel Blockers, Cardiac Glycosides, Diuretics, and NSAIDs prescribed drugs.

    - **Antiulcer Drug Initiative:** An on-line program utilizing the POS system issues alerts for an excessive dose or duration of antiulcer preparations. Such use will produce a payment denial which must be explained by the pharmacist through the entry of an override code into the POS system. The program also alerts for duplication of antiulcer therapies.

Medicaid Drug Rebate Program*:*

Identified by OBRA '90 legislation, drug rebates are intended to provide a method of capturing the lowest marketplace drug prices for the wide variety of drugs reimbursed to a broad spectrum of pharmacy (NDCs) and medical (J-Codes/HCPCS) providers in the Medicaid populations. Drug rebates are paid on a quarterly basis by calculation of the unit rebate amounts multiplied by the units dispensed to determine the rebate payments due Virginia Medicaid. Rebates are apportioned to the federal and state governments according to the Federal Funding Participation rate in effect on the date the moneys are returned to the program. Innovator drugs pay from 15 to 50 percent and generic drugs pay about 11 percent based on the largest documented quarterly discounts and the

average manufacturers' prices. This yields rebate amounts that approximate 18 percent of the drug expenditures by DMAS and is representative of the discounts found in the marketplace.

Clinic Services: Clinic services include diagnostic, therapeutic, rehabilitative or palliative items or services; psychiatric therapy; and renal dialysis services provided on an outpatient basis under the direction of a physician or dentist by a non-hospital facility that is organized and operated to provide outpatient medical care.

Date Services First Covered: 1969.

Exclusions From Coverage	Limits On Coverage	Co-Payments Required	Required Pre-Authorization	Reimbursement Method
• Routine physicals and immunizations if patient is over 21. • Telephone consultations. • Artificial insemination or in-vitro fertilization. • Services not provided under the direction of a physician or dentist, except for nurse midwife services.	• Physical therapy and occupational therapy limited to 5 visits per year unless approved by DMAS. • Psychotherapy limited to 5 visits per year unless approved by DMAS. • Induced abortions only when substantial endangerment to health or life of mother would occur if fetus were carried to term.	• Categorically Needy and Medically Needy recipi-ents pay a $1.00 per visit co-payment directly to health departments and other clinics licensed by the state. • No co-payments are required for children, pregnancy-related services, emergency services or institutional and nursing homes. • No co-payments are required for family planning services provided by local health department clinics.	• Pre-authorization required to exceed visit limits for physical therapy, occupational therapy and psychotherapy services.	• *Rehabilitation Agencies:* Payment is made according to Medicare cost reimbursement principles. • *Renal Dialysis Clinics, Ambulatory Surgical Centers, Health Department Clinics:* The lower of the program's fee schedule or provider's actual charge.

Other Practitioner Services: These include any medical or remedial services provided by a licensed practitioner other than a physician or dentist. Other practitioners may include podiatrists, nurse midwives (separately addressed), psychologists and optometrists.

Podiatry Services:

Date Services First Covered: 1969.

Exclusions From Coverage	Limits On Coverage	Co-Payments Required	Required Pre-Authorization	Reimbursement Method
• Preventive or routine foot care. • Non-surgical treatment of structural misalignment. • Cutting or removing corns, warts or calluses. • Experimental procedures. • Acupuncture.	• Limited to reasonable and necessary diagnostic, medical and surgical treatment of foot injuries and defects.	• Categorically Needy and Medically Needy recipients 21 years of age and older pay the following directly to the applicable provider: • Office visit: $1.00 per visit. • Inpatient visit: $3.00 per visit.	• Not required.	• The lower of the program's fee schedule or provider's actual charge.

Optometry Services:

Date Services First Covered: 1969.

Exclusions From Coverage	Limits On Coverage	Co-Payments Required	Required Pre-Authorization	Reimbursement Method
• Lenses and frames for persons 21 and over. • Repair of lenses and frames for persons 21 and over. • Professional ophthalmic dispensing fees for persons 21 and over. • Eye exercises (orthoptics) for all persons. • Photogray lenses. • Lens for cosmetic purposes.	• One routine comprehensive eye examination every 24 months. • Tinted lens only when medically justified. • Contact lens only when medically justified. • Repair of frames and lens once every 12 months. • Reimbursement for Wire frames are limited to the amount DMAS would reimburse for plastic	• Categorically Needy and Medically Needy recipients 21 years of age and older pay $1.00 per visit directly to the applicable provider.	• Not required.	• The lower of the program's fee schedule, or provider's actual charge.

	frames.			

Other Practitioner Services (continued):

Clinical Psychology Services:

Date Services First Covered: 1981.

Exclusions From Coverage	Limits On Coverage	Co-Payments Required	Required Pre-Authorization	Reimbursement Method
• More than 5 psychiatric sessions without prior authorization.	• Cannot exceed 3 sessions within a 7-day period. • Services of a licensed clinical social worker or licensed professional counselor must be provided under the direct supervision of a clinical psychologist when employed by the clinical psychologist.	• Categorically Needy and Medically Needy recipients 21 years of age and older pay the following directly to the applicable provider: • Office visit: $1.00 per visit. • Other visit: $3.00 per visit.	• Individual psychotherapy above 5 sessions.	• The lower of the program's fee schedule, or provider's actual charge.

Rehabilitation Services: Rehabilitation services include general physical therapy, occupational therapy and speech-language pathology services which are provided by acute care inpatient hospitals, rehabilitation hospitals, rehabilitation agencies, home health providers, and outpatient hospitals. In addition, intensive rehabilitation services provide a package of comprehensive rehabilitation nursing, speech-language pathology services, social services, psychology, therapeutic recreation, durable medical equipment and physical, occupation or cognitive therapies.

Date Services First Covered: Physical therapy and related services: 1969.
Other rehabilitative services: 1986

Exclusions From Coverage	Limits On Coverage	Co-Payments Required	Required Pre-Authorization	Reimbursement Method
• Alcohol and drug abuse therapy.	• Physical therapy, occupational therapy and speech therapy limited to 12 visits per year unless approved by DMAS. • Physical therapy and related services must be ordered by a physician and be provided only as an element of hospital inpatient or outpatient services, nursing home services, home health services, or other service that is reimbursed on a cost-related basis. • Intensive rehabilitation must be conducted under direct physician supervision and provide intensive skilled rehabilitative nursing, physical therapy, occupa-tional therapy, and if needed, speech therapy, cognitive rehabilitation, prosthetic-orthotic services, psychology, social work and therapeutic recreation.	• Refer to co-payment and deductibles for setting in which service is provided.	• Pre-authorization required to exceed visit limits for physical therapy and related services. • All intensive rehabilitation programs require pre-authorization and are not automatically covered.	• *Physical therapy and related services:* Payment is made on a cost-related basis according to the setting in which the service is rendered. • *Intensive rehabilitation inpatient services:* Same as inpatient hospital. • *Intensive rehabilitation outpatient services:* Same as outpatient hospital.

Hospice Services: Hospice Services are a medically directed, interdisciplinary program of palliative services for the terminally ill and their families. Hospice emphasizes the control of pain and symptoms by use of a team of professionals, including physicians, nurses, counselors, therapists, aides and volunteers. The majority of hospice services are delivered in the home with inpatient care available as needed. Hospice services require an initial and ongoing authorization and physician certification. To be reimbursed, the hospice must provide the following core services: nursing, physician, medical social services, counseling, and home health aide and homemaker services. In addition, if the patient's condition warrants it, durable medical equipment and supplies, drugs and biologicals and rehabilitation services (for symptom control and maintenance of activities of daily living) may be provided.

Date Services First Covered: 1990

Exclusions From Coverage	Limits On Coverage	Co-Payments Required	Required Pre-Authorization	Reimbursement Method
• Other coverage that hospice services replace.	• The nature of service determines coverage. Services must be medically necessary and appropriate. • Inpatient respite care limited to 5 consecutive days. • Inpatient care is generally limited to no more than 20% of hospice days.	• Not required.	• Requires physician certification and initial authorization of services from DMAS. • Hospice patients are exempt from pre-admission screening requirements but criteria for short-term inpatient admissions must be met.	• Reimbursement made on either cost or fee-for-service basis according to the type of service rendered.

Durable Medical Equipment: All medically necessary medical supplies and equipment for use in the home setting, are covered for Medicaid recipients, and those recipients being discharged from an intensive rehabilitation program or receiving Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.

Date Services First Covered: See specific services listed above.

Exclusions From Coverage	Limits On Coverage	Co-Payments Required	Required Pre-Authorization	Reimbursement Method
• Space-conditioning equipment, such as room humidifiers, air conditioners and air cleaners. • DME and supplies for any hospital or nursing facility resident, except for ventilators and associated supplies for nursing facility residents that have been preapproved by DMAS. • Furniture or appliances not defined as medical equipment (such as blenders, bedside tables, mattresses other than for hospital beds, pillows, blankets or other bedding, special reading lamps, chairs with special lift seats, hand-held shower devices, exercise bicycles, and bathroom scales). • Items that are only for the recipient's comfort and convenience or for the convenience of those caring for the recipient.	• See extensive list contained in Appendix B of current edition of *Medical Supplies and Equipment Manual*.	• Not required.	• See extensive list contained in Appendix B of current edition of *Medical Supplies and Equipment Manual*.	• Payments for medical supplies equipment and appliances for products not included on the fee schedule are based on DMAS' estimate of the usual charge for the item by all providers.

Continued

Durable Medical Equipment (continued):

Exclusions From Coverage (Continued)		
• Prostheses, except for artificial arms, legs and their supportive devices which must be preauthorized by DMAS. • Items and services which are not reasonable for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (*e.g.,* over-the-counter drugs, dentifrices, toilet articles, electric tooth-brushes, cosmetic items, sugar and salt substitutes, support stockings, etc.,	• Orthotics, including braces, splints and supports. However, orthotics may be provided in certain cases under Rehabilitative Services. • Home or vehicle modifications. • Items not suitable for use primarily in the home setting (*i.e.,* car seats, equipment to be used while at school, etc.)	• Equipment for which the primary function is vocationally- or educationally-related (*i.e.,* computers, environment control devices, speech devices, etc.)

Transportation Services: Emergency and non-emergency transportation services are provided with certain limitations to Virginia Medicaid Recipients in order to ensure that they have necessary access to and from providers of all medical services covered by the *Virginia State Plan*. Covered transportation services are divided into two major categories: ambulance and non-ambulance services. Non-ambulance services may include common carrier bus services (intra-city and inter-city), commercial taxicab services, wheelchair van services, stretcher van services volunteer drivers, and commercial air carrier services. DMAS changed the non-emergency transportation expense from a medical service to an administrative expense under federal Medicaid law. In July of 2001 DMAS began a statewide non-emergency transportation brokerage program.

Date Services First Covered: 1969.

Exclusions From Coverage	Limits On Coverage	Co-Payments Required	Required Pre-Authorization	Reimbursement Method
• Transport of nursing home patients to a physician's office or a hospital outpatient department when the needed medical care can be rendered in the nursing home. • Transport of recipients from nursing home to outpatient departments of hospitals or to clinics to obtain routine physical therapy. • Lateral transfers, except under certain conditions. • Transport of family members to visit a recipient or to consult with the recipient's physician. • Transport for routine physicals and immunizations except to receive EPSDT services. • Transport for long-term speech therapy. • Transport for picking up drugs at the pharmacy when the drugs can be delivered or mailed. • Transport to receive medical care not covered by the Medicaid program	• Non-emergency transportation authorized only to nearest provider of medical care.	• Not required.	• Not required. However, physicians and other providers must certify that the trip was actually made.	• Monthly payments for non-emergency brokered transportation are made to the transportation broker. The broker is responsible for payment to local subcontracted non-emergency transportation providers

Home and Community-Based Care Waiver Services: A variety of alternative services are provided through six home and community-based care waivers to individuals who are eligible for institutional placement under Medicaid rules. These are:

Elderly and Disabled Waiver:

This waiver is targeted to individuals who (1) meet the nursing facility level of care criteria (i.e., they are functionally dependent and require medical and nursing supervision of care) and (2) are determined to be at risk of nursing facility placement and for whom community-based care services under the waiver are the critical services that enable the individual to remain at home rather than being placed in a nursing facility. Services available under this waiver include personal care, adult day health care and respite care.

Date Services First Covered: Personal Care: November 1982
Adult Day Health Care and Respite Care: July 1989
Personal Emergency Response System: April 2002

Consumer-Directed Personal Attendant Services Waiver (CD-PAS):

The receipt of Personal Attendant Services under this waiver is an alternative to the Elderly and Disabled Waiver for those individuals who meet the criteria. These services allow a beneficiary to remain in his/her home or community and to take charge of his/her care, including the hiring, training, supervision and firing of the personal attendant.

Date Services First covered: Attendant Care: July 1997

Technology Assisted Waiver:

This waiver provides in-home care for individuals under 21 years of age who are dependent upon technological support and require substantial, ongoing nursing care and would otherwise require hospitalization. It also provides services for individuals 21 years of age and older who would otherwise require specialized care. Services available include, environmental modifications, personal care, private duty nursing and respite care in addition to assistive technology.

Date Services First Covered: Environmental Modifications
Private Duty Nursing and Respite Care: December 1988
Personal Care: July 1995
Assistive Technology

Home and Community-Based Care Waiver Services (continued)

AIDS Waiver:

This waiver provides home and community-based care to individuals with AIDS or who are HIV+ symptomatic who are at risk of institutionalization. Services available under the waiver include private duty nursing, personal care, respite care and case management. The AIDS Waiver is specifically targeted to individuals with AIDS or those who are HIV+ symptomatic who (1) meet the nursing facility level of care criteria (i.e., they are functionally dependent and require medical and nursing supervision of care) and (2) are determined to be at risk of nursing facility placement and for whom community-based care services under the waiver are the critical services that enable the individual to remain at home rather than being placed in a nursing facility. Services available under this waiver include personal care, respite care, private-duty nursing, case management, nutritional supplements, consumer-directed personal assistance services and consumer-directed respite care services.

Date Services First Covered: Personal Care, Respite Care, Case Management, Private Duty Nursing and Nutritional Supplements: Jan. 1991
Consumer-Directed Personal Attendant Services and Consumer-Directed Respite Care: February 2003

Mental Retardation Waiver:

This waiver (formerly two separate waivers which now have been combined into one) is available for the provision of home and community-based care to eligible mentally retarded clients who would otherwise require placement in an ICF/MR facility. Services currently available include companion services, crisis stabilization, residential supports, personal assistance services, respite care services, nursing services, environmental modifications, assistive technology, day support services, prevocational services, therapeutic consultation services, personal emergency response system (PERS) and supported employment services.

Date Services First Covered: Residential Support, Day Support and Therapeutic Consultation: January 1991
Supported Employment, Private Duty Nursing, Personal Care, Respite Care, Assistive Technology and Environmental Modification Services: July 1, 1994
Companion Care, PERS, Consumer-Directed Services: October 2001

Consumer Directed (CD) Services added to the Mental Retardation (MR) Waiver **(SEE NEXT PAGE)**

Home and Community-Based Care Waiver Services (continued)

Consumer Directed (CD) Services added to the Mental Retardation (MR) Waiver

With the effective date of the new Waiver regulations being October 17, 2001, there are now three Consumer-Directed Services that have been added and are now available in the MR Waiver. These are CD Personal Assistance, CD Respite and CD Companion. The individual is the employer in these services, and is responsible for hiring, training, supervising, and (if necessary) firing assistants or companions. The individual must be able to independently manage his or her own consumer-directed services, if they are unable to do so or if they are under the age of 18, a family caregiver must serve as the employer on the behalf of the individual.

CD Personal Assistance services provides direct assistance with personal care activities of daily living, access to the community, medication and other medical needs and monitoring health status and physical condition.

CD Respite Services provide a temporary, substitute care normally provided by family or other primary, unpaid caregiver of an individual. It is provided on a short-term basis because of the need for routine but periodic relief or emergency absence of the primary caregiver.

CD Companion Services provide non-medical care, socialization or supervision to adults.

All of the above services are provided in the individual's home or at various locations in the community. The individual must have an emergency back up plan in case the assistant or companion does not show up for work as expected or terminates employment without prior notice. Finding a back-up caregiver is the responsibility of the individual and family. Individuals who do not have a back up plan are not eligible for these services until one is found.

Date Services First Covered: CD Personal Assistance, CD Respite and CD Companion Service: October 17, 2001

Individual and Family Developmental Developmental Disabilities Support (DD) Waiver:

This waiver is available for eligible individuals age 6 and older who have a related condition who meet eligibility criteria for ICF/MR placement and who do not have a diagnosis of mental retardation. Services available include crisis stabilization, in-home residential supports, personal care services, respite care services, skilled nursing services, environmental modifications, assistive technology, day support services, therapeutic consultation services, prevocational services, supported employment services, consumer-directed services, PERS, support coordination, and family/caregiver training.

Date Services First Covered: July 1, 2000

Non-Medicaid Facility Based Services

Assisted Living Services: These are services provided by a licensed assisted living facility (ALF) for auxiliary grant adults who may have physical or mental impairments and require at least moderate assistance with activities of daily living. The Commonwealth currently makes a monthly Auxiliary Grant payment to the resident to enable him/her to pay for room and board and for minimal assistance with basic Activities of Daily Living (ADLs) and moderate assistance with Instrumental Activities of Daily Living (IADLs). ADLs include activities such as bathing, dressing, toileting, transferring, bowel, bladder and eating while IADLs include activities such as meal preparation, housekeeping, laundry, money management and medication administration. The Commonwealth has developed two levels of payment for the additional personal care needs of public pay assisted living residents: Regular Assisted Living Services and Intensive Assisted Living Services. Regular assisted living services means a level of service provided by ALFs to persons who have dependencies in two or more activities of daily living or are dependent in a behavior pattern described as abusive, aggressive, or disruptive. Intensive assisted living services originally meant services provided under the *Social Security Act, Section 1915(c)* waiver program to Medicaid recipients who have dependencies in four or more ADLs, or who have a combination of dependencies in ADLs and cognitive or behavior problems. The IAL Waiver program was not renewed by HCFA as of March 17, 2000.

Date Services First Covered: August 1, 1996.

Exclusions From Coverage	Limits On Coverage	Co-Payments Required	Required Pre-Authorization	Reimbursement Method
• The Intensive Assisted Living (IAL) Program excludes new recipients entering the program. It continues to exist for those recipients who were enrolled in the program prior to 3/17/00. This program will continue until all of the recipients move out of the IAL program. This program is not reimbursed by Medicaid and is paid for with state funds. • Individuals receiving waiver services through the E&D, AIDS, DD or Tech Waivers are not allowed to reside in ALFs.	• Eligibility is limited to individuals 18 years and older who receive an Auxiliary Grant or General Relief, meet the program criteria for the level of care and who are residing in an assisted living facility.	• Not required.	• Initial admissions for services in an ALF must be assessed and authorized by an assessor, who may be a case manager employed by a public human services agency or other qualified assessors (nursing home preadmis-sion screening teams or independent physicians) who have a contract with DMAS to complete the assessment for appli-cants for/residents of ALFs.	• The ALF resident receives the Auxiliary Grant and pays the ALF for care provided. • The Commonwealth, using all General Funds, reimburses the ALF a per diem vendor payment of $3.00/day for Regular Assisted Living Services, up to a maximum of $90/month. • In addition, the Commonwealth reimburses the ALF a per diem vendor payment of $6.00/day for Intensive Assisted Living Services, up to a maximum of $180/month.

General

Enrollment of Medicaid beneficiaries in some form of managed care -- either a primary care case management plan or a plan in which the provider is paid a monthly premium and is at full or partial financial risk for all costs of care -- has accelerated dramatically during the 1990s and into the new millennium, as shown in the following table. Enrollment is approved through the 1915(b) (freedom of choice) or 1115 (state health reform demonstration) waivers fully implement those changes.

Federal Fiscal Year	Number of Medicaid Beneficiaries Enrolled in Managed Care Plans	Number of Total Medicaid Recipients	Percent of Total Medicaid Beneficiaries Enrolled in Managed Care Plans
1991	2,696,397	28,279,781	9.5
1992	3,634,516	31,150,006	11.7
1993	4,808,951	33,432,025	14.4
1994	7,794,250	35,055,736	22.2
1995	11,619,929	36,281,586	32.0
1996	13,330,119	36,117,956	36.9
1997	15,345,502	33,554,590	45.7
1998	16,573,996	30,896,635	56.6
1999	17,756,603	31,940,188	55.6
2000	18,786,137	33,690,364	55.8
2001	20,773,813	36,562,567	56.8
2002	23,117,668	40,147,539	57.6

Source: Center for Mediicare and Medicaid Services

"Medicaid Managed Care" includes a broad array of health financing and delivery arrangements designed to eliminate inappropriate and unnecessary services and by relying more heavily on primary care and care coordination to improve health outcomes. Managed Care arrangements are characterized by the formal enrollment of individuals in a managed care plan, contractual arrangements between the provider and a payer, and some degree of medical management and utilization control performed by a primary care physician, a separate administering arm of the health plan, or both.

Medicaid Managed Care plans generally fall into three general categories.

Primary Care Case Management (PCCM) plans are very close to the traditional fee-for-service system. The beneficiary chooses a primary care provider (physician or clinic) from a Medicaid approved list, and that PCP provider becomes responsible for authorizing any specialty care the beneficiary needs. The provider is usually paid a case management monthly fee for the management of care and referrals, but is reimbursed on a regular fee-for-service basis for the care delivered to the patient. The provider is not at financial risk for the cost of care.

Capitated at-risk plans are ones in which the beneficiary receives all care through a single point of entry, and the plan is paid a fixed monthly premium per beneficiary for any health care included in the benefit package regardless of the amount of services actually used. A capitated plan can be a network of providers, all of whom participate in the plan and also participate in other plans or fee-for-services systems, or it can be one which hires all the physicians and they provide all the care required.

Partially capitated plans are a variation on the capitated at-risk plans. Sometimes the capitation rates are set so the risk is shared between the plan and the insurer. Typically they are used in situations in which there is insufficient experience, either with the cost of the benefit package or the population covered, for the insurer and provider to agree upon a fully capitated rate.

MEDALLION, Virginia's Primary Care Case Management Program

MEDALLION, Virginia Medicaid's Primary Care Case Management (PCCM) program began in 1991 as an experiment in managed care for eligible Aged, Blind, and Disabled populations. On December 23, 1991, Centers of Medicaid and Medicare Services (CMS) granted a 1915(b) waiver for MEDALLION to improve Medicaid recipients' quality of care and to assist in controlling the Commonwealth's escalating health care cost for the TANF and TANF-related Medicaid recipients. The program expanded to various parts of the Commonwealth and was expanded Statewide in 1994 covering 300,000 recipients.

The goals of MEDALLION include: enhancing access to care; providing for the continuity of care; providing a "medical home"; promoting patient compliance and responsibility when accessing medical care; and increasing physician participation in the program. This is accomplished by linking recipients with a source for coordinated primary care. As with other PCCM programs, the Primary Care Physician (PCP) acts as a gatekeeper, providing or coordinating the medical needs of the client. with coverage 7-day/week, 24-hour/day and assumes a longitudinal responsibility for their clients' health and illness and coordinates the use of the health care system, especially visits to specialists. Under the MEDALLION program, providers of primary care must be: general practitioners, family practitioners, pediatricians, gynecologists, internists, clinics or groups with one or more of the above specialists, or specialists who agree to provide primary care.

MEDALLION changed the way recipients and providers view Medicaid enrollees because it introduced the concept of a PCP in Medicaid. As a result, MEDALLION produces better medical outcomes and promotes the physician/patient relationship, preventive care, and patient education, while reducing the inappropriate use of medical services than their Fee-for-Service counterparts. The program contracted with the Williamson Institute for its first clinical and quality studies. MEDALLION was used in the development of the Virginia Health Outcomes Partnership (VHOP program), which later became the basis of the Department's disease management program. The MEDALLION program became the foundation of the *Options* and Medallion II program.

MEDALLION continues to be rated highly by physicians and recipients on satisfaction and access to care. MEDALLION continues to provide the Commonwealth with cost savings and health improvements for the Commonwealth's recipients. MEDALLION will continue to improve effectiveness by adopting new management tools that will allow us to identify and improve our service to the Medicaid populations without losing the heart of the program.

Medallion II, Virginia's Mandatory MCO Program

Medallion II, a mandatory Managed Care Organization program, builds on earlier DMAS initiatives to expand the use of managed care for the delivery of health care to Medicaid recipients. Medallion II was created for the purposes of improving access to care, promoting disease prevention, ensuring quality care, and reducing Medicaid expenditures. It has provided the Commonwealth with the most value per taxpayer dollar for the provision of high quality health care and provides an integrated, comprehensive delivery system to the recipients.

Medallion II began January 1, 1996 for Virginia Medicaid recipients covering managed care recipients in seven (7) Tidewater localities. Medallion II requires mandatory enrollment into a contracted Managed Care Organization (MCO) for certain group of Medicaid recipients. Medallion II expanded in November of 1997 to an additional six cities and counties adjacent to Tidewater. As a result of the success of Medallion II in the Tidewater area, effective April 1, 1999, DMAS further expanded Medallion II into 33 additional cities/counties in Central Virginia. These cities and counties included Richmond, Hopewell, Petersburg, and their surrounding counties. Effective October 1, 2000, Medallion II expanded to Areas Adjacent to Central Virginia which consisted of nine localities including Fredericksburg and Mecklenburg.

On December 1, 2001, the Department expanded Medallion II into 48 localities including the areas of Danville, Roanoke, Charlottesville, and Northern Virginia. To date, the Medallion II program affects approximately 103 localities and approximately 243,000 Medicaid recipients. The Medallion II program was changed for the last expansion to allow MEDALLION and the MCO to operate in the same area concurrently. This affected 33 areas where both programs are operating concurrently.

As of December 2001, seven MCO Partners serve the Medallion II Programs: Trigon HealthKeepers Plus by HealthKeepers, Trigon HealthKeepers Plus by Peninsula Health Care, Trigon HealthKeepers Plus by Priority Health Care, Sentara Family Care, Southern Health Care*N*et, UniCare by Wellpoint, and Virginia Premier. The program has been successful in enhancing access and availability of care by requiring MCOs to maintain an adequate network of physicians, hospitals, ancillary, transportation, and specialty providers. The MCOs provide extensive member services including 24-hour nurse advice lines, as well as offering enhanced services, e.g., adult dental and vision services; enhanced pre-natal programs; case management services; and group and individualized health education.

- George Mason University conducted an independent assessment in March 2000 and reported that the Medallion II program met or exceeded requirements for recipient access, quality of services, and cost effectiveness. The assessment further cited that over the prior two years of the program, there was an average savings of 6.10 percent, approximately $20.7 million savings to the taxpayers.

Pre- PACE (Program of All-Inclusive Care for the Elderly)

The 1995 General Assembly also directed DMAS to seek an 1115(a) waiver from CMS to implement one or more Programs of All-Inclusive Care for the Elderly (PACE) demonstration projects, effective July 1, 1995. PACE is an innovative model that seeks positive outcomes and cost savings by providing a range of integrated preventative, acute care, and long-term care services to manage the often complex medical, functional, and social needs of the frail elderly age 65 and over. The goal of PACE is to assist the individual to remain independent in a community-based setting and to live out the remainder of his/her life with dignity.

The program can provide:

- Adult day health center services,

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- Personal and home health care,
- Physical, occupational, and speech therapy,
- Socialization and recreational program,
- Meals and nutritional services in a day center,
- Durable medical equipment and supplies,
- Outpatient drugs,
- Transportation to and from the day center and to medical appointments,
- Physician and nursing care,
- Inpatient and outpatient hospital services, and
- Assisted living/nursing facility services.

An interdisciplinary team, consisting of professional and paraprofessional staff, assesses participants' needs, develops care plans, and delivers all services (including acute care services and when necessary I nursing facility services) which are integrated for a seamless provision of total care. PACE programs provide social and medical services primarily in an adult day health center, supplemented by in-home and referral services in accordance with the participant's needs.
PACE providers assume full financial risk for participants' care without limits on amount, duration, or scope of services. Virginia's PACE program began as a prepaid health plan through Sentara Lifecare Corporation, known as Sentara Senior Community Care and serves around 115 enrollees.

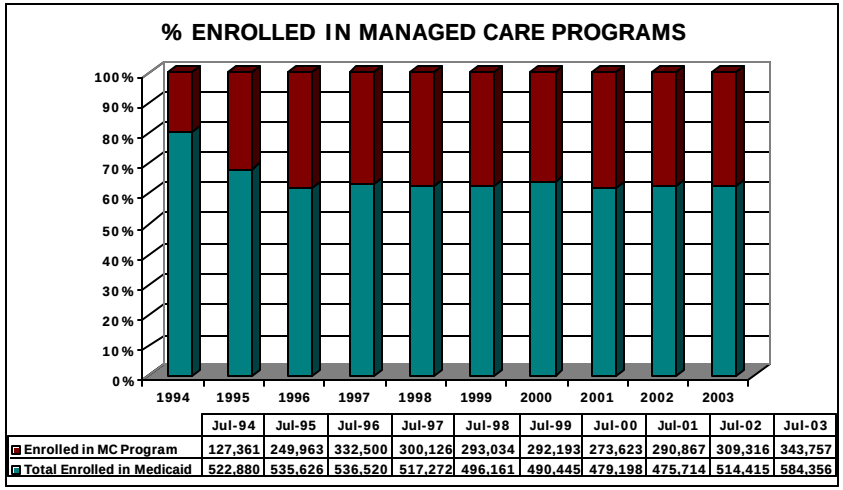
The scope of current PACE demonstration sites is small. There are currently 26 PACE demonstration sites. Each site serves an average of 200 enrollees, whose average age is 82. Virginia's PACE program began as a partially capitated arrangement in order to reduce the risk to providers while experience was gained, and subsequently transitioned to a fully capitated program after about 100 clients were enrolled.

Beneficiaries Enrolled in Managed Care Programs

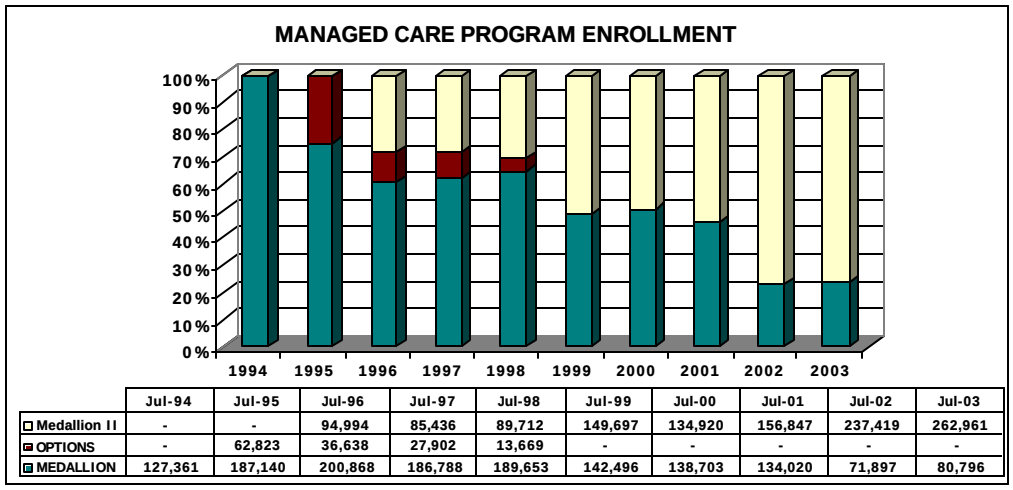
Virginia is aggressively pursuing managed care programs as a means of containing growth in Medicaid spending while maintaining access to care for low-income individuals. The dramatic growth in the numbers of individuals enrolled in various forms of managed care is shown in the table below.

	7-1-95	7-1-96	7-1-97	7-1-98	7-1-99	7-1-00	7-1-01	7-1-02	7-1-03
Total Enrolled in Medicaid	535,626	536,520	517,272	496,161	490,445	479,198	481,417	514,415	584,356
Total Enrolled in MC Programs	249,963	332,500	300,129	293,034	292,193	280,978	290,867	309,316	343,757
Medallion Program	187,140	200,868	186,788	189,653	142,496	138,703	134,020	71,897	80,796

Options Program	62,823	36,638	27,902	13,669	0	0	0	0	0
Medallion II Program	0	94,994	85,439	89,712	149,697	142,275	156,847	237,419	262,961
% Enrolled in MC Programs	46.7%	62.0%	58.0%	59.1%	59.6%	58.9%	61.3%	60.1%	58.8%



	Jul-94	Jul-95	Jul-96	Jul-97	Jul-98	Jul-99	Jul-00	Jul-01	Jul-02	Jul-03
Enrolled in MC Program	127,361	249,963	332,500	300,126	293,034	292,193	273,623	290,867	309,316	343,757
Total Enrolled in Medicaid	522,880	535,626	536,520	517,272	496,161	490,445	479,198	475,714	514,415	584,356



	Jul-94	Jul-95	Jul-96	Jul-97	Jul-98	Jul-99	Jul-00	Jul-01	Jul-02	Jul-03
Medallion II	-	-	94,994	85,436	89,712	149,697	134,920	156,847	237,419	262,961
OPTIONS	-	62,823	36,638	27,902	13,669	-	-	-	-	-
MEDALLION	127,361	187,140	200,868	186,788	189,653	142,496	138,703	134,020	71,897	80,796

OVERVIEW OF THE VIRGINIA MEDICAID PROGRAM
PROVIDERS

General

Medical services are rendered to eligible recipients through a network of participating providers (i.e., institutions, facilities, agencies, persons, partnerships, corporations, or associations) that are licensed by the appropriate state agencies and who have current, signed participation agreements with DMAS. The network totaled 48,338 providers as of June 30, 2002.

Number of Enrolled Providers

Date	General Hospitals	Nursing Homes	Physicians	Dentists/Dental Clinics	Pharmacies	MCOs	All Other Providers	Total Providers
6-30-97	100	308	21,571	963	1,733	11	15,707	40,393
6-30-98	99	309	18,250	829	1,706	10	16,846	38,049
6-30-99	98	313	21,414	926	1,788	7	19,673	44,219
6-30-00	99	309	22,378	929	1,780	6	20,423	45,924
6-30-01	97	318	21,456	621	1,596	7	21,704	45,799
6-30-02	95	222	23,564	735	1,609	7	22,191	48,338
6-30-03	95	229	24,012	824	1,632	7	23,547	50,346

State Plan for Medical Assistance

Each state operates its Medicaid program in accordance with its *State Plan for Medical Assistance,* which describes the state's basic eligibility, coverage, reimbursement and administrative policies. The State Plan must be approved by the Centers for Medicare and Medicaid Services (CMS) (formerly known as the Health Care Financing Administration - HCFA), the federal agency that administers the Medicaid and Medicare programs. Each state's State Plan is periodically updated to reflect changes in state policy or to conform to new federal requirements. CMS may use several mechanisms to ensure state compliance with federal requirements. The most common method is the disallowance action, under which CMS retrospectively disallows and recovers federal matching payments for state expenditures made in violation of federal requirements. An alternative process is the compliance action, under which CMS could prospectively withhold federal funds if it makes a determination that the State Plan no longer complies with federal requirements or that the administration of the plan is noncompliant; this process has never yet been carried to the point of actual withholding of funds.

Administrative Requirements

States must carry out the following major administrative actions in order to qualify for federal matching funds for its Medicaid program:

Single State Agency

A state Medicaid plan must provide for the establishment or designation of a single state agency with authority to administer or supervise the administration of the plan and include a certification by the attorney general of the state identifying the single state agency and citing the legal authority under which the agency administers or supervises the administration of the plan on a statewide basis, including the authority to make rules and regulations it follows in administering the plan or that are binding on local agencies that administer the plan. In Virginia, this agency is the Department of Medical Assistance Services.

Eligibility Determination

The State Plan must provide for a written agreement between the single state Medicaid agency and the state or federal agency making eligibility determinations for Medicaid. Determination of Medicaid eligibility for families or individuals under 21 years of age must be performed by the single state agency or the state agency administering or supervising the administration of the Title IV-A program. In states where recipients of SSI are automatically eligible, the state may contract with the Social Security Administration to determine eligibility for these beneficiaries, as well as for other aged, blind or disabled applicants, or it may perform its own determinations. States generally conduct their own determinations for the medically needy. In Virginia, the Department of Social Services makes most eligibility determinations. States are also required to "outstation" eligibility workers to give individuals the opportunity to apply for Medicaid at the sites where they receive health care.

Notice, Hearing and Appeal Concerning Benefits

The State Plan must provide an opportunity for a fair hearing before the state agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness. The state agency must grant an opportunity for a hearing to any individual who requests it in cases in which (1) an applicant believes a claim for services is denied or is not acted upon promptly, (2) a recipient believes the agency has taken an action erroneously, (3) a resident believes a nursing home acted erroneously in ordering his or her transfer or discharge, and (4) an individual believes a state made an erroneous determination with regard to preadmission and annual resident review requirements.

Utilization Control and Review and Medical Review

Medicaid law and regulations require states to develop a utilization review (UR) plan and provide for external reviews of certain facilities. Activities conducted by the facilities themselves include initial and periodic recertification of each patient's need for care, development of plans for the care of each patient, and operation of an approved utilization review program. The law requires state Medicaid plans to provide methods and procedures necessary to: (1) safeguard against unnecessary utilization of care and services, (2) assure that payments are consistent with efficiency, economy, and quality care, and (3) assure that payment is sufficient to enlist enough providers so that care and services are available under Medicaid at least to the extent that they are available to the general population in the geographic area.

Preadmission Screening and Resident Reviews

States must perform preadmission screening and resident reviews (when needed) to discover nursing home applicants or patients who are mentally ill or retarded to ensure that such individuals are not admitted to or maintained in nursing facilities unless they need the level of care the facility provides.

Recovery of Cost of Medicaid Services

States must try to recover costs of Medicaid services by (1) imposing liens on property sold by Medicaid patients and (2) seeking recovery from the estates of nursing facility or medical facility patients who were 55 or older when they received Medicaid services. Such estate recovery applies to Medicaid costs of nursing facility services, home and community based services, and related hospital and prescription drug services. States must establish procedures for waiving recovery in undue hardship cases.

Third Party Liability

The state Medicaid agency must take reasonable measures to determine the legal liability of third parties to pay for services for which Medicaid would otherwise have to pay. A third party is any entity that is or may be liable to pay all or part of the medical cost of injury, disease, or disability of a Medicaid applicant or recipient. States are required to integrate pursuit of third-party liability payments with the mechanized claims processing and information retrieval systems used to administer Medicaid programs.

Operation of a Medicaid Management Information System (MMIS)

State must operate systems that are:

- Adequate to efficient, economical and effective administration;
- Compatible with Medicare claims processing and information retrieval systems;
- Capable of providing accurate and timely data;
- Compliant with the requirements of the *Health Insurance Portability and Accountability Act of 1996*;
- Capable of receiving provider claims in standardized formats;
- Capable of electronically transmitting data in a format consistent with the Medicaid Statistical Information System (MSIS) for claims filed on or after January 1, 1999;
- Integrated with systems used to pursue third party payments.

Detection of Fraud and Abuse

Each state is required to establish methods for identifying and investigating cases of potential fraud and abuse. Special federal funding is available for state Medicaid Fraud Control Units (MFCUs), which investigate state law fraud violations. Federal agencies may also act on their own to pursue Medicaid fraud or abuse cases.

Provider Certification

States must determine which providers of services are eligible to participate in the program. Federal law is specific about the standards and certification procedures for institutional providers, such as hospitals and nursing facilities. For certain other kinds of providers, such as physicians and pharmacies, states generally follow their own laws.

Reports

States are required to file certain reports with CMS, among them being the HCFA-37, Medicaid Program Budget Report (filed quarterly); the HCFA-64, Statement of Medicaid Expenditures (filed quarterly); the HCFA-2082, Statistical Report on Medical Care: Eligibles, Recipients, Payments and Services (filed annually); and the HCFA-372, Annual Report on Home and Community-Based Service Waivers